

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967913</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/07/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CAPE WEST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4616-4614 SW 7 PL</b><br><b>CAPE CORAL, FL 33914</b> |                                                                                                                          |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {A 000}                                              | <p>Initial Comments</p> <p>An unannounced second revisit survey was conducted on 12/7/20 at Cape West, an assisted living facility in Cape Coral, Florida.</p> <p>This was a second follow-up to the complaint #2020012451, focused infection control and emergency power plan monitoring survey completed on 7/29/20.</p> <p>The previous deficiencies were found corrected and no new deficiencies were identified.</p> | {A 000}                                                                                          |                                                                                                                          |                          |                                                                    |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE