

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968274	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/07/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CAPE CORAL SHORES

**1318 SANTA BARBARA BLVD
CAPE CORAL, FL 33991**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A survey for complaint #2020010921 was conducted by desk review from through for Cape Coral Shores, an assisted living facility in Cape Coral, Florida. Complaint #2020010921 was substantiated at A0120. The following is description of the deficiency.	A 000		
A 120 SS=F	429.17(3).275(1); 59A-36.013(1) FAC Fiscal - Financial Stability 429.17 (3) In addition to the requirements of part II of chapter 408, each facility must report to the agency any adverse court action concerning the facility's financial viability, within 7 days after its occurrence. The agency shall have access to books, records, and any other financial documents maintained by the facility to the extent necessary to determine the facility's financial stability. 429.275 (1) The administrator or owner of a facility shall maintain accurate business records that identify, summarize, and classify funds received and expenses disbursed and shall use written accounting procedures and a recognized accounting system. 59A-36.013 Fiscal Standards. (1) FINANCIAL STABILITY. The facility must be administered on a sound financial basis in order to ensure adequate resources to meet resident needs pursuant to the requirements of chapter 408, part II, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter.	A 120		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968274	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/07/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CAPE CORAL SHORES

**1318 SANTA BARBARA BLVD
CAPE CORAL, FL 33991**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 120	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to submit financial records that were requested and was unable to show their rent was being paid timely. The findings included: On , two rent checks written to the building owner were reviewed. One check was written on for the rent of and and the second check was written on for the rent of and . On at 12:45 p.m., an interview was conducted with the Assisted Living Facility business owner. He said he submitted these checks to the building owner but she has not cashed them yet and does not know why they weren't cashed. He had not called the owner of building to find out why these checks were not cashed. On at 2:10 p.m., an interview was conducted with the building owner by phone. She said she is the landlord for Cape Coral Shores' building. She had not received any rent checks from the Assisted Living Facility business owner for the rent of , , and . At 3:15 p.m., the building owner called and she had not received any rent payments from the Assisted Living Facility business owner for the year 2020. Calls were made to the Assisted Living Facility business owner and a message was left on his voice mail on at 11:50 a.m., at 1:00 p.m., and at 9:50 a.m. The message was for him to submit his electric bill, utility bill, and phone bill of his assisted living facility to the	A 120		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968274	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/07/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CAPE CORAL SHORES

**1318 SANTA BARBARA BLVD
CAPE CORAL, FL 33991**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 120	Continued From page 2 surveyor. He was given the fax number to the Agency for Healthcare Administration Fort Myers office. As of _____ at 11:00 a.m., the Assisted Living Facility business owner had not returned these calls and had not submitted these bills to the Agency. The Assisted Living Facility business owner had not been able to ensure his facility is financially stable by not submitting these bills when requested and he was unable to show his rent had been paid for _____, _____, and _____. Class III	A 120		