

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967913	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/01/2021
NAME OF PROVIDER OR SUPPLIER CAPE WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 4616-4614 SW 7 PL CAPE CORAL, FL 33914		
(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 follow-up by desk review was conducted on 4/1/21 for Cape West, an assisted living facility in Cape Coral, Florida. The follow-up was in response to the relicensure survey completed on 9/29/20 and first follow-up completed on 12/7/20. Based on the facility's plan of correction and supporting documentation, the deficiencies were corrected as of 1/17/21.	A 000			

AHCA Form 3020-0001

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

TITLE

(X6) DATE