Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969729 | A. BUILDING: _____ B. WING _____ | R 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAMPTON MANOR OF CAPE CORAL | 1906 SKYLINE 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<br><br>An unannounced follow up survey was conducted on 6/5/24 at at Hampton Manor of Cape Coral, an assisted living facility in Cape Coral Florida.<br><br>This was a follow up to complaint survey for #2024005896 that was conducted on 5/1/24 through 5/2/14.<br><br>The previous deficiencies were found corrected and no new deficiencies were identified. | {A 000} | | |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE