

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969575	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/05/2024
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HIGHPOINT AT CAPE CORAL

**1701 FOUR MILE COVE PKWY
CAPE CORAL, FL 33904**

(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 An unannounced complaint survey for complaints #2023008345, #2023010172, #2023014537, #2024004715, #2024008953, and #2024009902, was conducted 11/4/24 through 11/5/24 at Highpoint at Cape Coral, an assisted living facility in Cape Coral, Florida. Complaint #2023008345 was substantiated without citation. Complaint #2023010172 was substantiated without citation. Complaint #2023014537 was unsubstantiated. Complaint #2024004715 was unsubstantiated. Complaint #2024008953 was unsubstantiated. Complaint #2024009902 was unsubstantiated. No deficiencies were found at the time of the visit.	A 000		

AHCA Form 3020-0001

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

TITLE

(X8) DATE