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
	AL11967943	A. BUILDING: _____ B. WING _____	R 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA COLONIA 1 ALF, INC	830 NE 10TH LANE CAPE CORAL, FL 33909

(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 survey by desk review was conducted on 7/9/25 through 7/10/25 for La Colonia 1 ALF, Inc, an assisted living facility in Cape Coral, Florida. The follow-up was in response to the relicensure, bed capacity increase, emergency power plan monitoring, health facility reporting system, and visitation form survey was conducted on 4/22/25. Based on the facility's plan of correction, and supporting documentation, the deficiencies were corrected as of 5/22/25 and no new deficiencies were identified at the time of the survey. .	{A 000}		

AHCA Form 3020-0001

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