

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
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)	
A 000	Initial Comments This is a Monitoring Review conducted on for Cape West Assisted Living Facility. The following citation was cited as a result of this monitoring:		A 000		
A 181	58A-5.026(2) FAC Emergency Mgmt - Plan Approval (2) EMERGENCY PLAN APPROVAL. The plan shall be submitted for review and approval to the county emergency management agency. (a) The county emergency management agency has 60 days in which to review and approve the plan or advise the facility of necessary revisions. Any revisions must be made and the plan resubmitted to the county office of emergency management within 30 days of receiving notification from the county agency that the plan must be revised. (b) Newly-licensed facility and facilities whose ownership has been transferred, must submit an emergency management plan within 30 days after obtaining a license. (c) The facility shall review its emergency management plan on an annual basis. Any substantive changes must be submitted to the county emergency agency for review and approval. 1. Changes in the name, address, telephone number, or position of staff listed in the plan are not considered substantive revisions for the purposes of this rule. 2. Changes in the identification of specific staff must be submitted to the county emergency management agency annually as a signed and dated addendum that is not subject to review and approval. (d) The county emergency management agency		A 181		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0009

WE5811

If continuation sheet 1 of 2

AHCA Form 3020-0001
STATE FORM



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

2012

Administrator
Cape West
4616-4614 SW 7th Place
Cape Coral, Florida 33914

Dear Administrator:

Re: Monitoring survey

This letter reports the findings of a monitoring survey that was conducted via Desk Review on 2012 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct the deficiency within thirty days of the date of this letter unless the Agency has approved another timeframe. **If you send us your approved Emergency Management Plan by 2012, Staff from this office will conduct a Desk Review to clear the deficiency identified on your survey.**

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call this office at 239-335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

HW:ss
Enclosure: State Form
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
<http://ahca.myflorida.com>



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