

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 11/15/2012
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 This is the follow-up to the Monitoring Review conducted on 11/01/12 for Cape West Assisted Living Facility. This follow-up was conducted by desk review on 11/15/12. The citation cited was cleared by this desk review.		{A 000}		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0099

WE5812

If continuation sheet 1 of 1

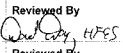
11/15/2012

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA /
Identification Number
AL11967913(Y2) Multiple Construction
A. Building
B. Wing(Y3) Date of Revisit
11/15/2012Name of Facility
CAPE WESTStreet Address, City, State, Zip Code
4616-4614 SW 7 PL
CAPE CORAL, FL 33914

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A0181 Reg. # 58A-5.026(2) FAC LSC	Correction Completed 11/15/2012	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By
State Agency
Reviewed By
CMS ROReviewed By

Reviewed ByDate:
11-15-12
Date:Signature of Surveyor:

Signature of Surveyor:Date:
11-15-12
Date:Followup to Survey Completed on:
11/1/2012Check for any Uncorrected Deficiencies. Was a Summary of
Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

November 15, 2012

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

Dear Administrator:

This letter reports the findings of a Monitoring survey revisit conducted via desk review on November 15, 2012 by representative(s) of this office.

Attached is the provider's copy of the Revisit Report, which indicates the previously cited deficiency was found corrected on the day of the revisit. **You will not receive a copy of this report in the mail; you will only receive this faxed report.**

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

Enclosures: State (3020) Form and Revisit Report

