STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968426	**05/07/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
LA COLONIA II ALF INC	**637-639 SE 12TH CT CAPE CORAL, FL 33990**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An announced Limited Nursing Services (LNS) survey was conducted on [redacted] at La Colonia II, an Assisted Living Facility (ALF) in Cape Coral, Florida.

The following is a description of the deficiencies cited.

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on record review and interview, the facility failed to have an approved Emergency Management Plan.

The findings included:

Review of facility records reveal no approved Emergency Management Plan.

Interview with Administrator on [redacted] at 5:00p.m., she stated, "I have been e-mailing Lee County [redacted] and the Fire Inspector about an approved Emergency Plan and no one has responded to me."

Class III

N278 - LNS - Records - 58A-5.031(3) FAC

Based on observation, record review, and interview, the facility failed to have a monthly assessment on 1 (Resident #1) out of 1 resident on reviewed.

The findings included:

Resident #1 was listed as Limited Nursing Services (LNS) resident, for twice daily [redacted] sugar testing. There was no monthly assessment found in Resident #1's record.

Staff A stated on [redacted] at 5:00 p.m., "I was not aware I had to do a monthly assessment."

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
La Colonia Ii Alf Inc
637-639 Se 12th Ct
Cape Coral, FL 33990

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies 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. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

sh
Enclosure: State Form

Fort Myers Field Office
2295 Victoria Avenue,
Fort Myers, FL 33901
Phone:(239) 335-1315; Fax:(239) 338-2372
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida