

# INSPECTIONS & APPEALS

TERRY E. BRANSTAD  
GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

KIM REYNOLDS  
LT. GOVERNOR

February 16, 2016

Ms. Sally Seeley, RN Manager  
Heritage Court  
1499 Office Park Road  
West Des Moines, IA 50265

**RE: Final Recertification Monitoring Evaluation Report – Heritage Court, West Des Moines, IA**

Dear Ms. Seeley:

Enclosed is the **Final Recertification Monitoring Evaluation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481–67 and 481–69. **No Regulatory Insufficiencies were found during this evaluation.**

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Enclosed you will find the Assisted Living Program Certificate **S0056** with effective dates of **January 8, 2016** through **January 7, 2018**.

If you have any questions in regard to this certification, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**.

Sincerely,

*Rose Boccella*

Rose Boccella  
Program Coordinator  
Adult Services Bureau

Enclosure

DEPARTMENT OF INSPECTIONS AND APPEALS

|                                                     |                                                                           |                                                                        |                                                        |
|-----------------------------------------------------|---------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>S0056</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/19/2016</b> |
|-----------------------------------------------------|---------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**HERITAGE COURT**

**1499 OFFICE PARK RD  
WEST DES MOINES, IA 50265**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 000                    | <p>481-67 Initial Comments</p> <p>Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site.</p> <p>General Population Program</p> <p>Number of tenants without cognitive disorder: 26<br/>Number of tenants with cognitive disorder: 1<br/>Total Population of Program at time of on-site: 27</p> <p>TOTAL census of Assisted Living Program: 27</p> <p>No regulatory insufficiencies were cited during the recertification conducted to determine compliance with certification of an Assisted Living Program.</p> | A 000               |                                                                                                                          |                          |

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

TITLE

(X6) DATE