

DEPARTMENT OF INSPECTIONS AND APPEALS

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>S0320</b>            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/21/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ASPEN HEIGHTS ASSISTED LIVING</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1410 ASPEN STREET<br/>HULL, IA 51239</b> |                                                                                                                          |                                                        |
| (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>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: 20<br/>Number of tenants with cognitive disorder: 4<br/>Total Population of Program at time of on-site: 24</p> <p>TOTAL census of Assisted Living Program: 24</p> <p>No regulatory insufficiencies were cited during the recertification visit 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