

12/14/17  
 PRINTED: 10/12/2017  
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 12/11/17

## DEPARTMENT OF INSPECTIONS AND APPEALS

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>S0106              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY COMPLETED<br><br>09/27/2017 |
| NAME OF PROVIDER OR SUPPLIER<br><br>COBBLE CREEK ASSISTED LIVING |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br>980 OAK STREET<br>SHELDON, IA 51201 |                                                                                                                          |                                              |
| (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                                                            | 481-67 Initial Comments<br><br>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.<br><br>General Population Program<br><br>Number of tenants without cognitive disorder: 12<br>Number of tenants with cognitive disorder: 0<br>Total Population of Program at time of on-site: 12<br><br>TOTAL census of Assisted Living Program: 12<br><br>The following regulatory insufficiency was cited during the recertification conducted to determine compliance with certification for an Assisted Living Program:                                                                  | A 000                                                                        |                                                                                                                          |                                              |
| A 118                                                            | 481-67.19(3) Record Checks<br><br>481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks.<br><br>67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to complete criminal, dependent adult abuse and child abuse checks prior to | A 118                                                                        |                                                                                                                          |                                              |

DIVISION OF HEALTH FACILITIES - STATE OF IOWA  
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

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If continuation sheet 1 of 2

PRINTED: 10/12/2017  
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DEPARTMENT OF INSPECTIONS AND APPEALS

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| DEPARTMENT OF INSPECTIONS AND APPEALS                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X2) MULTIPLE CONSTRUCTION                                                   |                                                                                                                                                                                                                                | (X3) DATE SURVEY COMPLETED |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>S0106                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | A. BUILDING: _____<br><br>B. WING: _____                                     |                                                                                                                                                                                                                                | 09/27/2017                 |
| NAME OF PROVIDER OR SUPPLIER<br><br>COBBLE CREEK ASSISTED LIVING |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>980 OAK STREET<br>SHELDON, IA 51201 |                                                                                                                                                                                                                                |                            |
| (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 118                                                            | Continued From page 1<br><br>employment for 1 of 2 staff reviewed (Staff B). Finding follows:<br><br>Record review revealed Staff B, hired 3/24/17. Continued record review revealed the Single Contract License and Background check, completed 4/4/17. The Program failed to complete criminal, dependent adult abuse and child abuse checks prior to employment of Staff B.<br><br>When interviewed on 9/27/17 the Administrator confirmed the Program did not complete the record check prior to Staff B beginning employment. | A 118                                                                        | Effective immediately, CCHL will make sure all criminal, dependent adult abuse + child abuse record checks are done PRIOR to any employment to our program. The program director has made up sheets to help with this process. |                            |
|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                              | Aimee Mlyn<br>Director<br>11-28-17                                                                                                                                                                                             |                            |

**DIVISION OF HEALTH FACILITIES - STATE OF IOWA**  
**STATE FORM**

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