

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/11/2017
NAME OF PROVIDER OR SUPPLIER COUNTRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 900 W 46TH ST DAVENPORT, IA 52806		
(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 Assisted Living Programs for People with Dementia (ALP/D) are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Memory Care Unit Number of tenants without cognitive disorder: 5 Number of tenants with cognitive disorder: 22 Total Population of Program at time of on-site: 27 TOTAL census of Assisted Living Program: 27 The investigation of Incident #70760-I and Incident #70763-I resulted in no regulatory insufficiencies cited. The revisit of Incident #70048-I and Complaint #70170-C was also completed. Previously cited regulatory insufficiencies were corrected.	A 000		

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

TITLE

(X6) DATE