

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IAALP083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/17/2018
NAME OF PROVIDER OR SUPPLIER HERITAGE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1499 OFFICE PARK RD WEST DES MOINES, IA 50265		
(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	<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>Number of tenants without cognitive disorder: 25</p> <p>Number of tenants with cognitive disorder: 0</p> <p>TOTAL census of Assisted Living Program: 25</p> <p>A recertification visit was conducted to determine compliance with certification for an Assisted Living Program. Complaint #73227-C was also investigated. No regulatory insufficiencies were identified.</p>	A 000		

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

TITLE

(X6) DATE