

DEPARTMENT OF INSPECTIONS AND APPEALS

| | | | |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0308 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 02/13/2018 |
|--|--|---|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER VILLAGE ASSISTED LIVING | STREET ADDRESS, CITY, STATE, ZIP CODE 2555 GUTHRIE AVENUE DES MOINES, IA 50317 |
|--|--|

| (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: 52 Number of tenants with cognitive disorder: 0 Total census of Assisted Living Program: 52</p> <p>There were no regulatory insufficiencies cited during the recertification visit conducted to determine compliance with certification rules.</p> | A 000 | | |

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____