

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>S0362</b>                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>06/18/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DEERFIELD RETIREMENT COMMUNITY INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>13731 HICKMAN ROAD</b><br><b>URBANDALE, IA 50323</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:<br/>Number of tenants without cognitive disorder: 5<br/>Number of tenants with cognitive disorder: 0<br/>Total population of Program at time of on-site: 17</p> <p>Total population of Program at time of on-site: 17</p> <p>No regulatory insufficiencies were cited during the investigation of Complaint #75994-C.</p> | A 000                                                                                            |                                                                                                                          |                                                                    |

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

TITLE

(X6) DATE