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|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>IAALP174</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                        |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/15/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>JOHN'S HARBOR MEMORY LOSS CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3520 GRAND AVE<br/>DES MOINES, IA 50312</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 for People with Dementia are defined by the 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: 4</p> <p>Number of tenants with cognitive disorder: 11</p> <p>TOTAL Census of Assisted Living Program for People with Dementia: 15</p> <p>No regulatory insufficiencies were cited during the investigation of Complaint #77038-C.</p> |                                                                              | A 000                                                                                   |                                                                                                                          |                                                        |

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

TITLE

(X6) DATE