DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0326	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENCE VILLAGE OF ANKENY MEMO	1275 SW STATE STREET ANKENY, IA 50023

(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 are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment:0 Number of tenants with cognitive impairment: 14 Total census: 14 The following regulatory insufficiency was cited during the investigation of Complaint #124565-C.	A 000		
A 315	481-69.25(1)n Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: n. A copy of guardianship, durable power of attorney for health care, power of attorney, or conservatorship or other documentation of a legal representative This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure tenant records included copies of documentation of durable power of attorney information. This pertained to 1 of 1 former tenants reviewed (Tenant C1). Findings follow: Review of Tenant C1's record on 4/23/25 revealed Tenant C1 had a Global Deterioration Scale (GDS) score of 4 and was noted to have a power of attorney (POA). A copy of the POA document could not be located in the tenant's record.	A 315	Regional Wellness Director in-serviced Wellness Director on the importance of obtaining appropriate documents on admission. All residents will have copy of guardianship, durable power of attorney, or conservatorship or other documentation of a legal representative as needed.	5/31/25

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

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0326	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENCE VILLAGE OF ANKENY MEMO	**1275 SW STATE STREET ANKENY, IA 50023**

(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 315	Continued From page 1 During the exit on 4/23/25 at 1:00 p.m. the Director and delegating nurse confirmed the Program failed to ensure the tenant's record included a copy of the required document.	A 315		