

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>570617</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/05/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>CORRIDOR CROSSING PLACE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>136 36TH AVENUE SW CEDAR RAPIDS, IA 52404</b>		
(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
R 000	<p>Initial Comments</p> <p>No deficiencies were cited during the survey conducted to determine compliance with licensing rules for a Residential Care Facility with a special classification for Memory Care.</p> <p>In addition to this survey, an onsite infection control survey was conducted. No deficiencies were cited during this survey.</p>	R 000		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

TITLE

(X6) DATE