

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/14/2021
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NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 BROOKRIDGE CIR ATLANTIC, IA 50022
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(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>General Population Program</p> <p>Number of tenants without cognitive disorder: 52 Number of tenants with cognitive disorder: 0 Total Population of Program at time of on-site: 52</p> <p>TOTAL census of Assisted Living Program: 52</p> <p>No regulatory insufficiencies were cited during the investigation of Complaint #92416-C or the onsite infection control survey.</p>	A 000		

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