

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0177	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/06/2023
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NAME OF PROVIDER OR SUPPLIER COURTYARD TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 717 W 3RD ST BOONE, IA 50036
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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>Number of tenants without cognitive impairment: 16</p> <p>Number of tenants with cognitive impairment: 0</p> <p>TOTAL census of Assisted Living Program: 16</p> <p>No regulatory insufficiencies were cited during the recertification conducted to determine compliance with certification for an Assisted Living Program.</p>	A 000		

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