DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **S0193**	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED **C** **03/09/2021**

NAME OF PROVIDER OR SUPPLIER **HERITAGE AT FOX RUN ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **3121 MACINEERY DRIVE** **COUNCIL BLUFFS, IA 51501**

(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 are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. General Population Program Number of tenants without cognitive disorder: 55 Number of tenants with cognitive disorder: 9 Total Population of Program at time of on-site: 64 TOTAL census of Assisted Living Program: 64 No regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification of an Assisted Living Program. No regulatory insufficiencies were cited during the onsite infection control survey or during the investigation of Incidents #92154-I, #95176-I, 95694-I, and Complaint #95174-C.	A 000		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE