

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0326</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 03/22/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>INDEPENDENCE VILLAGE OF ANKENY MC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>1275 SW STATE STREET ANKENY, IA 50023</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
A 000	<p>Initial Comments</p> <p>Assisted Living Programs for People with Dementia 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 disorder: 0 Number of tenants with cognitive disorder: 15</p> <p>TOTAL census of Assisted Living Program for People with Dementia: 15</p> <p>No regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification of an Assisted Living Program. An onsite infection control visit was also completed and resulted in no concerns identified.</p> <p>No regulatory insufficiencies were cited during the investigation of Incident #93417-I, Complaint #93426-C.</p>	A 000		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

TITLE

(X6) DATE