

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0421</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/04/2021</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PENNSYLVANIA PLACE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>ONE PENNSYLVANIA PLACE</b> <b>OTTUMWA, IA 52501</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><b>Initial Comments</b></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 disorder: 29 Number of tenants with cognitive disorder: 0 Total census of Assisted Living Program: 29</p> <p>An onsite infection control survey and Complaint #93826-C were completed. There were no regulatory insufficiencies were cited.</p>	A 000	<p><i>CPA 6/9/21</i></p>	
-------	---	-------	--------------------------	--

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