

DEPARTMENT OF INSPECTIONS AND APPEALS

|                                                  |                                                                        |                                                                       |                                                     |
|--------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>S0479</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>05/14/2024</b> |
|--------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------|

|                                                                 |                                                                                             |
|-----------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CENTER POINT HEIGHTS</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>800 MUSTANG LANE<br/>CENTER POINT, IA 52213</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 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: 26</p> <p>Number of tenants with cognitive impairment: 1</p> <p>Total census: 27</p> <p>No regulatory insufficiencies were cited during the initial certification visit conducted to determine compliance with certification rules 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 \_\_\_\_\_