

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IAALP037 HFD	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2022
NAME OF PROVIDER OR SUPPLIER CLEARVIEW ESTATES ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST COLUMBUS MOUNT AYR, IA 50854		
(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. Tenants without cognitive impairment: 9 Tenants with cognitive impairment: 0 Total census: 9 No regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification rules for an Assisted Living.	A 000		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE