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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>IAALP410 HFD</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/25/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GRAND HAVEN RETIREMENT COMMUNITY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>201 EAST FRANKLIN STREET<br/>ELDRIDGE, IA 52748</b>                          |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>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 disorder: 68<br/>Number of tenants with cognitive disorder: 3<br/>TOTAL census of Assisted Living Program: 71</p> <p>No regulatory insufficiencies were cited during the initial certification visit conducted to determine compliance with licensing rules for an Assisted Living Program.</p> | A 000                                                                            |                                                                                                                          |                          |                                                        |

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

TITLE

(X6) DATE