

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0424	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/19/2021
NAME OF PROVIDER OR SUPPLIER COPPER CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 609 HWY 150 NORTH WEST UNION, IA 52175		
(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 population served. The census numbers were provided by the Program at the time of on-site. ASSISTED LIVING PROGRAM Number of tenants without cognitive disorder: 6 Number of tenants with cognitive disorder: 2 TOTAL census of Assisted Living Program: 8 At the time of the onsite infection control visit, no regulatory insufficiencies were cited.	A 000		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

TITLE

(X6) DATE