DEPARTMENT OF INSPECTIONS AND APPEALS

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | S0473 | A. BUILDING: _____ B. WING _____ | 06/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MEADOWVIEW OF CLIVE | 3300 BERKSHIRE PARKWAY CLIVE, IA 50325 |

| (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<br><br>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.<br><br>Tenants without cognitive impairment: 65<br><br>Tenants with cognitive impairment: 4<br><br>Total census: 69<br><br>No regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program and investigation of Complaint 131753-C. | A 000 | | |

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE