

DEPARTMENT OF INSPECTIONS AND APPEALS

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>S0333</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>10/25/2016</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOMESTEAD OF ALBIA</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6590 165TH STREET</b><br><b>ALBIA, IA 52531</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>481-67 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>Dementia-Specific Program by Definition</p> <p>Number of tenants without cognitive disorder: 21<br/>Number of tenants with cognitive disorder: 5<br/>Total Population of Program at time of on-site: 26</p> <p>TOTAL census of Assisted Living Program: 26</p> <p>No regulatory insufficiencies were cited during the investigation of Incident #62213-I and 62214-C.</p> | A 000                                                                                       |                                                                                                                          |                                                                    |

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

TITLE

(X6) DATE