

DEPARTMENT OF INSPECTIONS AND APPEALS

|                                                     |                                                                           |                                                                        |                                                        |
|-----------------------------------------------------|---------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>S0322</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/27/2017</b> |
|-----------------------------------------------------|---------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

**HOMESTEAD OF KNOXVILLE MEMORY CARE CENTE** **711 SOUTH WILLETTTS DRIVE**  
**KNOXVILLE, IA 50138**

| (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>Dementia-Specific Program by Dedication</p> <p>Number of tenants without cognitive disorder: 1<br/>Number of tenants with cognitive disorder: 10<br/>Total Population of Program at time of on-site: 11</p> <p>TOTAL census of Assisted Living Program: 11</p> <p>No regulatory insufficiencies were cited during the Recertification conducted to determine compliance with certification for an Assisted Living Program for People with Dementia (ALP/D).</p> | A 000               |                                                                                                                          |                          |

DIVISION OF HEALTH FACILITIES - STATE OF IOWA  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE