

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0313	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/11/2019
NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF OSCEOLA MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 334 NORTH WEST VIEW DRIVE OSCEOLA, IA 50213		
(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 type of population served. The census numbers were provided by the Program at the time of the on-site. Dementia-Specific Program Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 8 Total population of Program at time of on-site: 9 No regulatory insufficiencies were cited during the investigation of Complaint #83704. At the time of the complaint visit, the revisit of investigations #82570-C, #82394-C, #82372-C and #82374-C was also conducted. All previously cited regulatory insufficiencies were determined to be corrected.	A 000		

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

TITLE

(X6) DATE