STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALP261	A. BUILDING _____ B. WING _____	08/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD ESTATES AT HAWTHORNE CROSSING	601 HAWTHORNE CROSSING DR. SE BONDURANT, IA 50035

(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 General Population Number of tenants without cognitive disorder: 17 Number of tenants with cognitive disorder: 6 Memory Care Unit Number of tenants without cognitive disorder: 17 Number of tenants with cognitive disorder: 6 TOTAL Census of Assisted Living Program for People with Dementia: 46 A recertification visit was conducted to determine compliance with certification for an Assisted Living Program. Complaint #84442-C was also investigated. There were no regulatory insufficiencies identified.	A 000		

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