

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IAALPD313 HFD	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/06/2019
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 for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Memory Care Unit Number of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 8 TOTAL Census of Assisted Living Program for People with Dementia: 10 No regulatory insufficiencies were cited during the Investigation of Complaint #84638-C and #84881-C.		A 000		

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

TITLE

(X6) DATE