

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IAALP085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2020
NAME OF PROVIDER OR SUPPLIER HOLY SPIRIT			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 W 25TH ST SIOUX CITY, IA 51103		
(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 type of population served. The census numbers were provided by the Program at the time of the on-site. General Population Program Number of tenants without cognitive disorder: 16 Number of tenants with cognitive disorder: 3 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 9 TOTAL census of Assisted Living Program for People with Dementia: 28 No regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification of an Assisted Living Program. No regulatory insufficiencies were cited during the onsite infection control survey. No regulatory insufficiencies were cited during the investigation of Complaint #93802-C.	A 000			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE