STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALP039	A. BUILDING _____ B. WING _____	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CENTERVILLE	19999 ST JOSEPH'S DRIVE CENTERVILLE, IA 52544

(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. General Population Number of tenants without cognitive disorder: 11 Number of tenants with cognitive disorder: 6 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 5 TOTAL Census of Assisted Living Program for People with Dementia : 22 No regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program for People with Dementia. The following regulatory insufficiency was cited during the investigation into Complaint #100900-C.	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This Requirement is not met as evidenced by: Based on interview and record review, the program failed to follow its policy on Discharge Criteria for 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: Record review on 8/17/22 revealed Tenant C1 received a 30-day notice of discharge on 10/6/21. The program provided Tenant C1 and her legal representative with the telephone number of the state long-term care ombudsman but not the address.	A 150		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALP039	A. BUILDING _____ B. WING _____	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CENTERVILLE	19999 ST JOSEPH'S DRIVE CENTERVILLE, IA 52544

(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 150	Continued From Page 1 Additional record review on 8/17/22 revealed Tenant C2 received a 30-day notice of discharge on 6/23/22. The program did not have documentation in the medical record from Tenant C2's physician providing a rationale for why the discharge was necessary. The program provided Tenant C1 and her legal representative with the telephone number of the state long-term care ombudsman but not the address. Review of the Program's Discharge Criteria policy revealed before a resident was transferred or involuntarily discharged, the Director or his/her designee shall perform the following: Record the reason for the transfer or discharge in the resident's medical record, which shall be substantiated as follows: a. The resident's physician shall document the rationale for transfer or discharge in the resident's medical record if the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met by the facility. Each written transfer or discharge notice was to include the address and telephone number of the state long-term care ombudsman. The Executive Director confirmed these findings on 8/18/22 at 10:15 AM.	A 150		