

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: SO485	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/10/2024
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NAME OF PROVIDER OR SUPPLIER EDENCREST AT KETTLESTONE MEMORY CAF	STREET ADDRESS, CITY, STATE, ZIP CODE 805 SE TALLGRASS LANE WAUKEE, IA 50263
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(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	<p>Initial Comments</p> <p>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.</p> <p>Number of tenants without cognitive impairment: 0 Number of tenants with cognitive impairment: 4 Total census: 4</p> <p>No regulatory insufficiencies were cited during the initial visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia.</p>	A 000		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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