

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IAALPD369 HFD	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2021
NAME OF PROVIDER OR SUPPLIER EDENCREST AT BEAVERDALE			STREET ADDRESS, CITY, STATE, ZIP CODE 3410 BEAVERDALE AVENUE DES MOINES, IA 50310		
(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: 29 Number of tenants with cognitive disorder: 2 Memory Care Unit Number of tenants without cognitive disorder: 3 Number of tenants with cognitive disorder: 22 TOTAL Census of Assisted Living Program for People with Dementia: 56 During the investigation of complaint 93271-C, 93965-C, 94460-C and an infection control survey no regulatory insufficiencies cited.		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