

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0450</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/14/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>EDENCREST AT THE TUSCANY MC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1600 8TH STREET SE ALTOONA, IA 50009</b>
--	--

(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>General Population Number of tenants without cognitive disorder: 16</p> <p>Number of tenants with cognitive disorder: 4</p> <p>Memory Care Unit Number of tenants without cognitive disorder: 0</p> <p>Number of tenants with cognitive disorder: 7</p> <p>TOTAL Census of Assisted Living Program for People with Dementia: 27</p> <p>A recertification visit was conducted to determine compliance with certification for an Assisted Living Program. Complaints #101295-C, 101457-C and 102654-C were also completed. No regulatory insufficiencies were cited.</p>	A 000		

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