DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0471	A. BUILDING: ______ B. WING ______	C **10/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT TIMBERLINE	**14001 DOUGLAS PARKWAY** **URBANDALE, IA 50323**

(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 visit. Tenants without cognitive impairment: 1 Tenants with cognitive impairment: 10 Total census: 11 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia (ALP/D).	A 000	see attached POC 11/5/25	
A 155	481-69.23(1)b Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: b. Requires routine, two-person assistance with standing, transfer or evacuation This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the program failed to identify a tenant as exceeding criteria for retention for an Assisted Living Program for People with Dementia (ALP/D) for 1 of 3 tenants reviewed (Tenant #1). Finding follows: 1. Observations in the ALP/D common area on 10/06/25 at 5:00 p.m., 10/07/25 at 8:00 a.m. and	A 155		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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
	S0471	A. BUILDING: ______ B. WING ______	C 10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT TIMBERLINE	**14001 DOUGLAS PARKWAY URBANDALE, IA 50323**

(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 155	Continued From page 1 10/09/25 at 9:30 a.m. revealed Tenant #1 seated in a wheelchair. During interview on 10/06/25 at 1:15 p.m. Staff A stated Tenant #1 might need two staff to assist her with transfers more than half the time. She said Tenant #1 needed two staff to assist her to the toilet most of the time. During interview on 10/06/25 at 3:00 p.m.., Staff B said Tenant #1 often needed two staff assistance with transfers. She indicated Tenant #1 routinely needed two staff to transfer in and out of bed. During interview on 10/09/25 at 9:40 a.m. Staff C indicated Tenant #1 consistently needed two staff to assist her with transfers. During interview on 10/09/25 at 9:45 a.m. Staff D said Tenant #1 always needed two staff to assist with transfers and routinely used a wheelchair. Record review on 10/08/25 revealed Tenant #1's health and functional assessment and her service plan, both dated 9/10/25, indicated she needed stand by assistance for mobility and transfers. Both documents noted Tenant #1 used a cane and/or wheelchair for mobility. Her service plan indicated she needed stand by assistance for walking short distances and needed a wheelchair for longer distances. During interview on 10/09/25 at 10:10 a.m. the Executive Director (ED) and Regional Clinical Services Director/Registered Nurse (RN) noted Tenant #1 had significant decline since her most recent evaluation and service plan in September. Neither disagreed Tenant #1 routinely needed	A 155		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0471	A. BUILDING: ______ B. WING ______	C **10/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT TIMBERLINE	**14001 DOUGLAS PARKWAY URBANDALE, IA 50323**

(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 155	Continued From page 2 two staff to assist her with transfers. The RN said she planned to complete updated assessments this week. The ED indicated he talked with Tenant #1's family recently regarding the need for a higher level of care, but did not document the conversation or give formal notice.	A 155		

ok

Edencrest at Timberline ALP/D Plan of Correction

481-69.23(1)b

The preparation and execution of this Plan Of Correction does not constitute admission or agreement by Edencrest at Kettlestone of the truth of the facts alleged or conclusions set forth in this Statement of Insufficiencies. The Plan of Correction is submitted in response to the statement.

1. The resident declined quickly and did not require a routine 2-person assist. She was on the mend when we scheduled a care conference with family to discuss a possible higher level of care. Resident experienced a quick decline and passed away with hospice services at the community.

2. Education provided to the wellness team on 11/5/25 by the Clinical Services Coordinator. Education was provided to the resident assistants on 11/5/25 to communicate with the director of wellness either verbally or written on any observed changes in condition. Education provided to all directors of wellness regarding the hospice waiver by the Clinical Services Coordinator.

3. If a patient is declining or changes in condition are observed, a call will be made to the regional director of clinical services or designee to determine if a higher level of care is needed or if a hospice waiver needs to be obtained.

4. The regulatory insufficiency has been corrected. The director of wellness will monitor on a regular basis and as needed.