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
	SO485	A. BUILDING: _____ B. WING _____	C 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT KETTLESTONE MEMORY CARE	805 SE TALLGRASS LANE WAUKEE, IA 50263

(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. Number of tenants without cognitive impairment: 0 Number of tenants with cognitive impairment: 6 Total census: 6 The following regulatory insufficiencies were cited during the investigation of Incidents 128141-I, 130026-I ans Complaints #128788-C ans 129203-C.	A 000	See attached POC 7/16/25	
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide adequate and appropriate care, treatment, and services to 2 of 3 former tenants (Tenants C1 and C2). Findings follow: 1. Record review on 8/6/25 revealed the Program's internal investigation of Tenant C1's	A 160		

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
	SO485	A. BUILDING: _____ B. WING _____	C 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT KETTLESTONE MEMORY CARE	805 SE TALLGRASS LANE WAUKEE, IA 50263

(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 160	Continued From page 1	A 160		

fall on 7/8/25. Staff discovered Tenant C1 on the floor when they arrived for the day shift at 6:00 a.m. Staff A, who had been assigned to Tenant C1, reported she could not help Tenant C1 get up. Tenant C1 had no apparent injuries. Staff B contacted Emergency Medical Services (EMS) because Tenant C1 could not transfer due to weakness. EMS arrived at 7:15 a.m. and transported Tenant C1 to the Emergency Room (ER) for evaluation. The tenant did not sustain any injuries.

When interviewed by the Program on 7/8/25, Staff A stated she heard Tenant C1 call for help at approximately 4:00 a.m. After using the bathroom, Tenant C1 missed the bed and fell to the floor. Staff A attempted to assist but said she could not lift Tenant C1 due to her weight. Staff A admitted she did not have a phone to call for assistance and left Tenant C1 on the floor until day shift staff arrived. She stated she gave Tenant C1 a pillow and blanket and Tenant C1 did not complain of pain.

Record review on 8/7/25 revealed Tenant C1's service plan, signed on 6/16/25 and 6/23/25, noted the tenant required hourly safety checks. Tenant C1 had a Global Deterioration Scale (GDS) score of 4 (moderate cognitive decline). Staff documented safety checks on 7/8/25 at 2:06 a.m., 3:11 a.m., and 4:13 a.m.

During an interview on 8/7/25 at 1:30 p.m., the administrative team confirmed staff failed to perform required hourly safety checks. They stated the Program suspended Staff A for failing to call for assistance and leaving Tenant C1 on the floor. Staff A never returned to work. The team also reported camera footage showed Staff A entered Tenant C1's room multiple times

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
	SO485	A. BUILDING: _____ B. WING _____	C 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT KETTLESTONE MEMORY CARE	805 SE TALLGRASS LANE WAUKEE, IA 50263

(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 160	Continued From page 2 between 4:00 a.m. and 6:00 a.m. but failed to assist Tenant C1, who remained on the floor. 2. Record review on 8/7/25 revealed the timeline of Tenant C2's elopement. Staff D last saw Tenant C2 in his room at 7:38 p.m. on 4/12/25. At 8:57 p.m., Tenant C2 knocked on the Program's front door. The Program's review showed Tenant C2 removed window block inserts from his second-story window. Staff later found the inserts and a screen under his bed. Tenant C2 tied three sheets together and lowered them out of the window. Tenant C2 had a GDS score of 4 moderate cognitive decline and reported that he either fell a few inches or approximately 20 feet. Continued record review revealed Tenant C2 had no apparent injuries when found, though he complained of back pain. The tenant wore jeans, a t-shirt, and tennis shoes. The tenant was sent to the hospital for evaluation. The tenant had an abrasion to his forearm. Further review of Tenant C2's service plan, signed on 3/28/25 and 3/31/25, revealed the tenant required hourly safety checks and identified him as at risk for elopement with deficits in judgment. Review of staff documentation of safety checks revealed Staff E recorded requred safety checks for 7:00 p.m., 8:00 p.m., and 9:00 p.m. on 4/12/25 at 8:41 p.m. During an interview on 8/7/25 at 1:30 p.m., the administrative staff confirmed the documentation indicated staff failed to complete hourly checks appropriately. The Program suspended Staff E, who did not return to work.	A 160		

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
	SO485	A. BUILDING: _____ B. WING _____	C 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT KETTLESTONE MEMORY CARE	805 SE TALLGRASS LANE WAUKEE, IA 50263

(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

ok

Edencrest at Kettlestone Plan of Correction

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. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.

   Staff was immediately suspended pending investigation and was ultimately separated from employment.
2. Measures taken to ensure the problem does not recur

   Educated staff on 7/16/25 regarding communication and proper protocols. There is a cellphone, landline, and app on tablets for staff members to communicate at all times. All new hires receive documented education on these communication tools.
3. How the Program plans to monitor performance to ensure compliance.

   Staff documentation is regularly audited by the Wellness Director or designee for compliance.
4. The date by which the regulatory insufficiency will be corrected.

   Complete and ongoing as of 7/16/25.