

**Iowa Department of Inspections and Appeals
Health Facilities Division
Adult Services Civil Penalty Citation**

Date: September 4, 2025
Program Name: Edencrest at Timberline (ALP/D)
Address: 14001 Douglas Parkway Urbandale, IA
Type of Action: #126889-I, 128523-I, 128349-C, 128351-C, 128514-C 128812-C, 126927-I & 128350-C
Date(s) of Action: 6/2/25 – 6/5/25
FC # 10896

State Rule #	State Rule	Amount of Civil Penalty
Iowa Administrative Code (IAC) 481-67.3(2)	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. Based on interview and record review the Program failed to consistently ensure tenants received care, and treatment which were adequate and appropriate. This pertained to 1 of 1 former tenant (Tenant C1) identified in self-reported incident 126927-I. Finding follows: Record review on 6/3/25 revealed an Incident Report (IR) dated 2/20/25. The IR described Tenant C1 on the floor of the bathroom when staff summoned the Registered Nurse (RN). Tenant C1 fell from the toilet after her shower when staff went to retrieve her socks. Tenant C1 attempted to get up from the toilet. Tenant C1 reported pain to her head, neck and right arm and leg. A skin tear to her right arm, swelling and bleeding was noted on left posterior of her head. The IR documented Emergency Medical Services (EMS) called, family was called and vital signs assessed. Tenant C1 went to the hospital via EMS. Further review of Program documentation revealed Tenant C1 was admitted to the hospital on 2/21/25 with rib and lumbar fractures and a liver hematoma. Further review revealed Tenant C1's Progress Note dated 2/20/25 authored by former Wellness Director. The note stated Tenant C1 could not confirm what happened when she attempted to get up from the toilet where staff placed her before walking away to retrieve socks. Record review on 6/4/25 revealed Tenant C1's Service Plan (SP) signed 2/7/25 and 2/10/25. The service plan included stand by assistance for bathing, toileting and transferring. Record review on 6/4/25 revealed the Program failed to provide	\$4000.00

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	Staff A and B with re-training regarding stand by assistance as directed by Tenant C1's service plan. When interviewed on 6/4/25 at 9:10 a.m. Regional Director of Clinical Services confirmed Staff A and B failed to be present within arm's reach to prevent injury while Tenant C1 used the toilet (stand by assistance). She also confirmed neither staff received disciplinary action and/or retraining regarding stand by assistance after the incident involving injuries to Tenant C1. During the exit on 6/5/25 at 1:00 p.m. the administrative staff confirmed Program staff failed to provide stand by assistance as directed by Tenant C1's service plan. The lack of stand by assistance resulted in injuries to Tenant C1.	
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