

**Iowa Department of Inspections, Appeals & Licensing
Health and Safety Division
Adult Services Civil Penalty Citation**

Date: 10/8/2025
Program Name: Edencrest at Kettlestone Memory Care
Address: 805 SE Tallgrass Lane Waukee, IA 50263
Type of Action: Investigation #128788-C and #130026-I
Date(s) of Action: 8/4/25 – 8/7/25
Citation #: 10923

State Rule #	State Rule	Amount of Civil Penalty
Iowa Administrative Code (IAC) 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. 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 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	\$3,000.00

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	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 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 required 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.	
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