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
	IAALP495	A. BUILDING: _____ B. WING _____	C 10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT TIMBERLINE	1401 DOUGLAS PKWY 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 are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site visit. Tenants without cognitive impairment: 55 Tenants with cognitive impairment: 10 Total census: 65 No regulatory insufficiencies were cited during the initial certification visit conducted to determine compliance with certification rules for an Assisted Living Program (ALP). No regulatory insufficiencies were cited during the investigations of Incident #129935-I and #130092-I. The following regulatory insufficiency was cited during the investigation of Incident #130517-I.	A 000	See attached POC 10/4/25	
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 appropriate care and	A 160		

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A 160	Continued From page 1	A 160		

service for one of one tenant reviewed who utilized a WanderGuard device (Tenant #4). Findings follow:

Record review on 10/07/25 revealed an internal investigation for Tenant #4 regarding an incident on 10/04/25 when she left the building unattended and sat outside for approximately 30 minutes before staff went outside to be with her. According to the investigation, staff saw Tenant #4 in the dining room around dinner time about 20 minutes before she went out the exit door unobserved at 5:41 p.m.

Review of surveillance video revealed Tenant #4 walked out the main building exit doors at 5:41 p.m. on 10/04/25 and headed toward her right. (Chairs were located outside on the sidewalk to the right of the exit doors, but not visible on the surveillance camera.) At 5:51 p.m. Tenant #4 held an exit door open for people entering the building. Staff A went out the exit doors and headed to the right at 6:11 p.m. Staff A walked back into the building alone at 6:27 p.m. Tenant #4 walked about into the building by herself at 6:30 p.m.

Tenant #4's service plan dated 10/03/25 indicated safety checks eight times per shift and a WanderGuard device on her right wrist. Staff should check placement and functioning of the WanderGuard device twice daily. Tenant #4's updated Global Deterioration Scale (GDS) completed 10/03/25 noted a score of 5, which indicated moderately severe cognitive decline. Her previous GDS, dated 8/29/25, listed a GDS of 3, or mild cognitive decline. According to her Wandering Risk Assessment dated 10/03/25, Tenant #4 was at moderate risk for wandering.

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A 160	Continued From page 2 A progress note by the Regional Clinical Services Director/Registered Nurse (RN) dated 10/03/25 indicated a change of condition (assessments and service plan) was completed for Tenant #4 due to cognitive status. The RN noted the new GDS score of 5. The note also documented recent agitation and confusion. According to the progress note, the RN and Executive Director (ED) called Tenant #4's daughter to discuss a move to the memory care unit. They set up a meeting for the following Monday, 10/06/25 and agreed to implement a WanderGuard and visual checks eight times per shift. A progress note by the RN on 10/04/25 at 6:06 p.m. indicated staff reported they discovered Tenant #4 sitting outside the front door with other tenants without her WanderGuard on. The RN instructed staff to stay with the tenant at all times when outside. The tenant should have 1:1 supervision until the WanderGuard was put back on. RN entry at 8:40 p.m. indicated the WanderGuard was back on Tenant #4. During interview on 10/07/25 at 12:50 p.m. the Community Relations Director (CRD) stated she was the manager on duty on 10/04/25 until approximately 2:00 p.m. No manager was on site after she left the building. The CRD was aware Tenant #4 had a new WanderGuard device. Tenant #4's daughter arrived around lunchtime to take the tenant on an outing. The CRD said she removed the WanderGuard device from Tenant #4's wrist prior to the outing, as she had been trained in the past. She said she told Tenant #4's daughter to notify staff when they returned so staff could re-apply the WanderGuard device. The CRD left the device and a note in the staff	A 160		

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room, so the second shift staff would see it. The CRD said when trained on the WanderGuard system approximately one year prior, staff were told to remove the WanderGuard device from the tenant if they left the building for an outing. The device should be re-applied when the tenant returned to the building. The CRD said it didn't occur to her the other staff might not know how to re-apply the wrist device.

During interview on 10/07/25 at 2:10 p.m. Staff B stated Staff A informed her on the afternoon of 10/04/25 that Tenant #4 wasn't wearing her WanderGuard device. Staff B indicated she didn't know how to re-apply the device and asked Staff A about it, but she didn't know how to do it either. Staff B said she told Staff A to contact the RN or ED regarding Tenant #4's WanderGuard. Later in the afternoon, Staff B talked with the RN on the phone about a different issue and told the RN about the WanderGuard. The RN indicated she would check to see if someone could come in and re-apply it. After dinner, around 6:00 p.m., Staff B saw Tenant #4 through the front window, sitting outside. Staff B notified the RN, who directed a staff to stay with Tenant #4 until the WanderGuard device was re-applied. Staff A went outside to sit with Tenant #4. Staff C came into work around 6:00 or 6:30 p.m. and she then stayed with Tenant #4 until someone came in later in the evening to re-attach the WanderGuard device to Tenant #4's wrist. Staff B said she had worked at the program for almost one year and was never trained on how to put on or take off the WanderGuard device. She thought staff were not supposed to remove them.

During interview on 10/08/25 at 2:30 p.m. Staff A said she was working when Tenant #4's daughter

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A 160	Continued From page 4	A 160		

returned with the tenant on the afternoon of 10/04/25. The daughter asked Staff A to re-apply the WanderGuard wrist device, but Staff a didn't know how to do it. Staff A checked with Staff B, who also didn't know how to attach the device. Staff A said she thought she tried to contact the ED or RN regarding the WanderGuard and might have left a text or message. After dinner, Staff B told her the RN said a staff needed to stay with Tenant #4 until the WanderGuard was put back on her. Staff A went outside to sit with Tenant #4. Staff A didn't recall coming back inside the building 2-3 minutes before Tenant #4, but indicated staff could see the tenant through the large front window.

A review of nurse delegation documentation signed by the previous RN indicated Staff A and Staff B were trained on alarm use, which included the use of the WanderGuard alarm system. However, both staff stated they were not trained on how to remove and apply the WanderGuard wrist device.

During interview on 10/07/25 at 1:40 p.m. the RN said Staff B first called her on 10/04/25 at 5:52 p.m. to inform her the staff working at the program (Staff A and Staff B) didn't know how to re-apply the WanderGuard device to Tenant #4. The RN said she told Staff B to call the ED. Staff B called the RN back at 6:06 p.m. and told her Tenant #4 was sitting outside without the WanderGuard. Tenant #4 had a history of sitting outside the building with other tenants. The RN told Staff B a staff member must stay with Tenant #4 until someone came to the program to re-apply the WanderGuard device on the tenant. The RN stated she didn't know staff were previously trained to remove the WanderGuard

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A 160	Continued From page 5 device when tenants left the building. She said she later checked with the ED, who indicated he also believed the devices were supposed to be temporarily removed when tenants left the building. This was not correct information at the time of the incident on 10/04/25; the WanderGuard wrist device should have not been removed when Tenant #4 left the building on an outing. The RN confirmed the staff working when Tenant #4 returned to the building reported they didn't know how to re-apply the device to Tenant #4's wrist.	A 160		

ok

Edencrest at Timberline ALP Plan of Correction

481-67.3(2)

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. Staff provided one on one attention until the Wanderguard bracelet was replaced.

2. Education provided to all staff regarding Wanderguard devices on 10/4/25. All guidance related to the administration and monitoring of a Wanderguard device will come from the executive director or the director of wellness only.

3. The director of wellness will continue to perform assessments on a regular basis and as needed.

4. The regulatory insufficiency was corrected immediately on 10/4/25.