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
	S0355	A. BUILDING: _____ B. WING _____	C 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT GREEN MEADOWS	6750 CORPORATE DRIVE JOHNSTON, IA 50131

(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. Tenants without cognitive impairment: 27 Tenants with cognitive impairment: 19 Total census: 46 No regulatory insufficiencies were cited during the investigation of Complaint #130440-C. The following regulatory insufficiencies were cited during the investigation of Complaint #130346-C and/or the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia.	A 000		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to administer medications as prescribed by the tenant's physician for 3 of 3	A 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0355	A. BUILDING: _____ B. WING _____	C 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT GREEN MEADOWS	6750 CORPORATE DRIVE JOHNSTON, IA 50131

(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 285	Continued From page 1	A 285		

tenants reviewed (Tenant #1, Tenant #3, and Tenant #C3). Findings follow:

1. Record review on 12/15/25 revealed Tenant #1's October 2025 Medication Administration Record (MAR) included an order for a Lidocaine 4% patch to be applied to her shoulder topically one time a day for pain. The MAR identified a date of 10/16/25 and indicated the reason under key code "9" which meant "Other/See Progress Notes".

A review of Tenant #1's progress note from 10/16/25 revealed the order and the noted text "Medication was not administered" but failed to identify the reason why the medication was not administered.

During a follow up interview on 12/15/25 at 5:10 p.m. the Executive Director (ED) and visiting ED acknowledged the Medication Administration Record and progress notes revealed the Lidocaine patch for Tenant #1 was not administered and stated they had no explanation and didn't know why it wasn't administered.

2. Record review on 12/15/25 revealed Tenant #3's medication error incident report, dated 10/04/25 with an incident description listed as "Resident received all AM medications on 10/03/25 at 2000" (8:00 p.m.). The incident report noted the immediate action taken was to "hold all AM medications on 10/04/25, and then resume normal medication schedule thereafter".

Review of Tenant #3's October 2025 MAR reflected on 10/04/25 the morning medications were administered instead of documented as held or unavailable according to the instructions noted on the incident report.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0355	A. BUILDING: _____ B. WING _____	C 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT GREEN MEADOWS	6750 CORPORATE DRIVE JOHNSTON, IA 50131

(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 285	Continued From page 2 During a follow up interview on 12/15/25 at 5:10 p.m. the ED and visiting ED acknowledged the medication error incident report instructions to hold the AM medications on 10/04/25 and acknowledged the documentation revealed Tenant #3's AM medications were instead documented as being administered on 10/04/25. 3. Record review on 12/15/25 revealed Tenant #C3's medication error report dated 1/29/25 with an incident description listed as "RA Accidentally gave morphine instead of lorazepam." A review of Tenant #C3's September 2025 Medication Administration Record included an order for Morphine 0.25mls (5mg), to be administered every four hours as needed for pain with a start date of 1/30/25. During a follow up interview 12/15/25 at 5:10 p.m. the ED and visiting ED acknowledged the medication error incident report and morphine order start date as listed on the MAR and provided no explanation on how the administration of morphine could have occurred on 1/29/25, but stated the program "did the incident report and followed the process (for medication errors)." On 12/15/25 at 5:30 p.m. the ED, visiting ED, the Regional Director of Operations, (and via Regional Director of Clinical Services and the Regional Memory Care Specialist/Interim program nurse via phone) confirmed the above findings.	A 285		
A 395	481-69.26(4)a Service Plans	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0355	A. BUILDING: _____ B. WING _____	C 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT GREEN MEADOWS	6750 CORPORATE DRIVE JOHNSTON, IA 50131

(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 395	Continued From page 3 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the program failed to ensure the service plan was individualized and addressed identified needs for 1 of 9 tenants reviewed (Tenant #2). Finding follows: Review of the Program's provided entrance form on 12/11/25 identified Tenant #2 utilized bedrails. A review on 12/15/25 of Tenant #2's service plan dated 4/29/25 reflected no mention of the need or preference for bedrails. Observation on 12/15/25 at 4:30 p.m. of Tenant #2's room and bed, conducted in the presence of the Executive Director (ED) and visiting ED, revealed Tenant #2 had quarter-length bedrails in place on both sides of the bed. During a follow up interview on 12/15/25 at 5:10 p.m. the ED and visiting ED confirmed the above observation and lack of information regarding the use of bedrails on Tenant #2's service plan.. On 12/15/25 at 4:20 p.m. the new program Executive Director (ED) and visiting ED from another program who assisted with the survey/investigation visit reviewed Tenant #2's service plan and acknowledged the service plan failed to identify the use of bedrails.	A 395		

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
	S0355	A. BUILDING: _____ B. WING _____	C 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT GREEN MEADOWS	**6750 CORPORATE DRIVE JOHNSTON, IA 50131**

(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