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

Date: June 26, 2025
Program Name: Meadowview Memory Care Village
Address: 3005 F Avenue NW Cedar Rapids, IA 52405
Type of Action: 125098-C, 126308-C
Date(s) of Action: between 5/19/25 and 5/28/25
Citation #: 10846

State Rule #	State Rule	Amount of Civil Penalty
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 provide appropriate care and treatment for 1 of 3 former tenants reviewed (Tenant C1). Finding follows: On 5/19/25 record review revealed Tenant C1 died unexpectedly at the program on the evening of 11/16/24. Tenant C1 was 89 years old with a diagnosis including Alzheimer's disease, hypertension and osteoarthritis. She scored a 6 on the Global Deterioration Scale (GDS) on 9/24/24, which indicated severe cognitive decline. Tenant C1 had a Do Not Resuscitate (DNR) order in place at the time of the death. She was not under hospice care. An incident report (IR) for 11/15/24 indicated an unwitnessed fall to the floor around 6:35 p.m. Staff A documented Tenant C1's eyes were fluttering and she was acting unusual. Staff A called the Registered Nurse (RN), who directed the tenant to be sent to the emergency room (ER). A progress note written by the RN on 11/16/24 at 1:16 a.m. indicated Tenant C1 returned to the program from the ER with no acute findings. Tenant C1's son reported the tenant was very agitated at the ER and was given medication to calm her. An IR for 11/16/24 indicated Staff A mistakenly gave Tenant C1 another tenant's medication around 6:20 p.m. Staff A documented Tenant C1 was yelling out in pain, as she had a fall the day before. Staff A wrote she mistakenly gave Tenant C1 another tenant's medications when rushing to pass medications. Staff A notified the RN. Vitals were acceptable and Tenant C1 was responsive. The RN told Staff A to keep an eye on her. Staff A also documented Tenant C1's left side had been limp all day. A progress note written by the RN on 11/16/24 at 9:30 p.m. indicated she was walking into work when staff approached her and said Tenant C1 was not responding. The RN found the tenant slumped over in a wheelchair. She was pale and lips were blue. The RN detected no respirations or blood pressure and determined the tenant to be	**$6000.00**

	deceased. The RN notified the primary care provider (PCP) and county medical examiner. A progress note written by the RN on 11/16/24 at 11:00 p.m. indicated the county medical examiner came to assess Tenant C1 and interview staff. He was updated about the recent fall and the medication error. The medical examiner stated the medication error did not contribute to the tenant's death. Tenant C1's death certificate listed date and time of death as 11/16/24 at 10:45 p.m. Place of death was Meadowview Memory Care Village. Cause of death was listed as Cerebral Vascular Accident, with other significant conditions of Alzheimer's disease and hypertension. No autopsy was done. On 5/20/25 at 2:45 p.m. Staff A confirmed she worked second shift on 11/16/24 and administered the evening medication. When Staff A came into work at 2:00 p.m. Tenant C1 was not her usual self. She seemed dazed. Tenant C1 typically walked and paced around the unit, but on 11/16/24 she was unable to walk. A first shift told Staff A that Tenant C1 was limp on her left side, which was unusual. Staff A said Tenant C1 yelled out in apparent pain (more so than usual) and held her head with one arm, while rocking her body back and forth (unusual) for much of the second shift. The screaming/yelling became more intense around 5:00 p.m. Staff A said she rushed to give Tenant C1 her evening medication, because she received scheduled Acetaminophen and a medication for anxiety/agitation. Staff A mistakenly gave Tenant C1 another tenant's medication around 6:20 p.m. Staff A immediately realized her mistake and called the Registered Nurse (RN). Staff A said she told the RN of the medication error and reported Tenant C1's vital signs, but didn't mention the symptoms of yelling in pain, left side weakness, holding her head and rocking her body and forth. Staff A said the RN checked with the primary care provider (PCP) and called to tell her the medication error should not be a problem, but to keep an eye on the tenant. Staff A said Tenant C1 sat in a wheelchair near the nurses' station. She yelled and cried off and on until around 8:30 p.m. when she began to get drowsy and sleepy. Staff looked over at her every few minutes. A while later Staff C said Tenant C1 wasn't breathing. Staff summoned the RN, who was in the building at that time. The RN assessed Tenant C1 and said she was deceased. On 5/19/25 at 2:05 p.m. and 5/21/25 at 2:50 p.m. Staff B said she worked second shift on 11/16/25. She said Tenant C1 was in a wheelchair, which was unusual since the tenant typically walked independently. Staff B took Tenant C1 to the bathroom and noticed she was drowsy and didn't use one arm at all, which she typically used to hold the grab bar. Staff B tried to encourage Tenant C1 to use the arm, but it was limp. Tenant C also had difficulty bearing weight on one of her legs. Staff B said she told Staff A and Staff C about the weakness in Tenant C1's arm and leg, but she didn't know if anyone notified the RN.	

	On 5/21/25 at 9:15 a.m. Staff D said she worked first shift on 11/16/25. Tenant C1 was not her usual self. She stayed in bed for most, if not all, of first shift. Staff tried to get her up, but she didn't bear weight. Tenant C1 typically walked around independently. She seemed kind of groggy and less alert than usual. She didn't eat breakfast or lunch. Staff D said she didn't recall weakness in either arm. She called the RN to notify her of the grogginess, not walking and not eating. Staff D said she checked the tenant's vital signs and also reported those to the RN. The RN said to keep an eye on the tenant. On 5/21/25 at 11:50 a.m. the PCP said she was not informed on 11/16/24 of Tenant C1's symptoms of weakness on one side, inability to walk, yelling in pain, holding her head and rocking back and forth. The PCP indicated those symptoms were concerning and could be signs of a stroke. She said the RN told her of the tenant having weakness on one side only after Tenant C1 passed away. If she had been notified of those symptoms prior to Tenant C1's death, she would have recommended consulting with the power-of-attorney regarding sending the tenant back to the ER for another brain scan. The PCP confirmed she did not believe the medication error led to the tenant's death. On 5/21/25 at 4:00 p.m. the Linn County Medical Examiner recalled the death of Tenant C1. He didn't remember anyone telling him of the medication error, but when told of the medications involved, the ME said those medications would not have caused the death. The ME reviewed his notes and said Tenant C1 had a fall and ER visit on 11/15/24. The ER found nothing significant when they did x-rays and a brain scan. On 11/16/24, Tenant C1 had general weakness, used a wheelchair and had weakness in one arm. The ME suspected the tenant had a stroke, which might have been connected to the fall the day before. According to his notes from talking with staff, Tenant C1 was last seen alive at 9:15 p.m. The tenant was not breathing when the RN checked her at 9:30 p.m. After talking with the PCP, the ME determined the cause of death was likely a stroke. On 5/21/25 at 1:45 p.m. the RN confirmed Tenant C1's death on the evening of 11/16/24 was unexpected. The RN said the tenant fell to the floor on the evening of 11/15/24 and went to the ER for assessment. The ER reported no acute findings. The RN recalled Staff D called her during first shift of 11/16/24 to report Tenant C1 was groggy/sleepy, not eating and not walking. The RN said it was not unusual for Tenant C1 to sleep late and she assumed the tenant might have been tired after the late night at ER and receiving sedatives. Staff D didn't tell the RN of weakness on one side. The RN was scheduled to work that night, so she planned to assess Tenant C1 at that time. Staff A called the RN around 6:30 p.m. to tell her she mistakenly gave Tenant C1 another tenant's medications. Staff A checked the tenant's vital signs, which were not concerning. The RN contacted the PCP regarding the medication error and they didn't see a need to send the tenant to ER for assessment. The RN said staff didn't tell her of the other symptoms such as weakness on one side, yelling in suspected pain, holding head while rocking back and forth	

	and ongoing inability to walk. No one notified her of those symptoms on second shift, until after Tenant C1's death. On 6/18/25, the Executive Director confirmed staff were delegated to notify the nurse when a tenant has a sudden change of condition or when a tenant complains of severe pain with or without known injury.	