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

Date: January 22, 2026
Program Name: Meadowview Memory Care Village
Address: 3005 F Ave NW, Cedar Rapids, IA 52405
Type of Action: Investigation #130519
Date(s) of Action: 10/13/25 – 10/16/25
Citation #11024

State Rule #	State Rule	Amount of Civil Penalty
481-67.5(2)f(4)	**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.** Based on interview and record review, the program failed to ensure medication was administered to an unknown number of tenants as prescribed. Findings follow: 1) Record review on 10/13/25 revealed an undated investigation into an incident which occurred on 10/3/25 at approximately noon. A medication manager hired through a staffing agency, Staff A, attempted to give Tenant #2 morning medication (Hydroxyzine 50 mg., Metoprolol Tartrate 100 mg., Seroquel 25 mg., Terbinafine 250 mg. and Furosemide 20 mg. which she refused multiple times. Staff A then crushed the pills and put them in chocolate milk. The milk was given to Tenant #2 who was sitting in the dining room with other tenants and Staff A walked away. When she came back, the empty glass of milk was in front of Tenant #1. Staff A immediately contacted the Director of Nursing (DON) who was not in the building, but on-call. The DON provided instructions for staff to take vitals every fifteen minutes. The DON then contacted Tenant #1's medical provider who recommended sending her to the emergency room (ER). A review of the 10/3/25 Emergency Room (ER) notes indicated Tenant #1 was a 91-year old female with a history of Alzheimer's disease, bradycardia, hypertension and hypokalemia who	**$6000.00**

	presented after taking another tenant's medication. When she arrived at 1:34 PM, she was oriented at baseline, answering questions and alert. When her vitals were checked at 2:00 PM, her blood pressure was 98/62, heart rate 49, respiratory rate 12. While there, she had bradycardic episodes in the upper 20's. Tenant #1 was externally paced (a temporary medical procedure that used electric current delivered through pads on the chest to stimulate the heart to beat) and an atropine and epinephrine drips were started. This improved her blood pressure and heart rate significantly and the external pacing was able to be discontinued. Tenant #1 was admitted to the ICU with an epinephrine drip. She was able to return to the program on 10/6/25 at her baseline with no new orders. A review of the October Medication Administration Record (MAR) for Tenant #2 revealed her morning medications should have been administered at 8:00 AM (Hydroxyzine, Seroquel, Terbinafine and Metoprolol Tartrate) and 9:00 AM (Furosemide). On 10/13/25 at 3:05 PM, The DON reported Staff A could administer the pills one hour before or one hour after the times listed on the MAR. On 10/14/25 at 11:40 AM Staff A was interviewed and reported Tenant #2 was having a rough day. She tried to give her space and had the Care Coordinator attempt to administer the medication. At lunch time, Staff A had the tenant sit down in the dining room. She crushed Tenant #2's medication and put them in milk. She stepped away for a couple of minutes to grab something from the medication cart and was stopped by another tenant's family member. Staff A admitted she knew she shouldn't have walked away from Tenant #2. When she returned, the milk was sitting in front of Tenant #1. She contacted the Director of Nursing (DON) and was told to take Tenant #1's vitals every 15 minutes. During an interview with the Care Coordinator on 10/15/25 at 9:00 AM she reported Staff A came to the office she shared with the DON to report the medication error. They returned to the medication cart and the Care Coordinator was asked to take over Staff A's responsibilities which included administering medication to the other tenants and monitoring Tenant #1's vitals. She described the situation as really chaotic. The Care Coordinator didn't think she was verbally told to take Tenant #1's vitals but she did see these instructions on the vitals sheet. After Tenant #1 finished eating lunch, staff took her back to her room where she remained until the ambulance crew arrived. The Care Coordinator recalled telling others she needed to get down to Tenant #1's room to check her vitals but did not do so prior to the arrival of	

	the ambulance, around 1:00 PM. She walked with the ambulance crew to Tenant #1's room and when they arrived Tenant #1 was sitting in her chair and seemed fine. When interviewed on 10/13/25 at 3:05 PM, the DON stated Staff A did a number of incorrect things when administering medication to Tenant #2 on 10/3/25. She gave medication to Tenant #2 outside of the acceptable time parameters. She crushed the tenant's medication when there wasn't an order to do so. In addition, she walked away from Tenant #2 before she finished swallowing all of the chocolate milk, leaving the medication unattended. The Care Coordinator failed to check Tenant #1's vitals every 15 minutes. 2) A. Record review on 10/13/25 of an incident report dated 8/28/25 at 4:00 PM revealed the DON was contacted when Tenant #3 was found slumped over in his wheelchair and could not be roused. Staff B wrote she was confused about giving the PRN, or as needed, medication along with the scheduled medication. They contacted his wife and Tenant #3 was transported to the ER. The DON reviewed the MAR and he received a scheduled oxycodone at noon and a PRN at 3:00 PM. Staff B stated she may have also given the tenant his bedtime dose with the 3:00 PRN dose of medication. The oxycodone was not signed out in the controlled substance book or the MAR. A review of the 8/28/25 ER notes identified Tenant #3 as an 84-year old male with a medical history of COPD, dementia, hypertension and sleep apnea. He arrived after receiving an accidental oxycodone overdose. While in the ambulance, Tenant #3 became hypoxic and required bag mask ventilation. He was given 0.4 mg. of Narcan but was subsequently able to be weaned to room air. Lab work completed in the ER revealed a mild acute kidney injury. He received IV fluids. Tenant #3 was observed in the ER, appeared stable and returned to the program on 8/29/25. Staff B was interviewed on 10/14/25 at 10:25 AM. She stated she was very busy on 8/28/25: 3 tenants asked her for Tylenol, 2 tenants requested help and the DON wanted her to get snacks for others. Staff B provided Tenant #3 the PRN as he was reporting pain in his back, hips and legs. She also decided to give him his bedtime medication as there were times he wanted to go to bed early or had behaviors. Staff B thought it was best to provide medication to him on his schedule, not on the times written on the MAR. After Tenant #3 received the medication she noticed he was falling asleep but initially didn't think anything of it. Staff B	

	thought someone should help him to bed and asked another employee to help her get him up. They had a difficult time assisting him to stand which was unusual. She decided to contact the DON. Tenant #3 kept falling asleep when she tried to speak with him and by this time she knew something was wrong. She got Tenant #3's vitals and was only able to get readings on his temperature and oxygen. His oxygen ranged from 81-87. When the DON arrived the ambulance was called and he went to the ER. She was immediately removed from the medication cart. B. On 10/14/25 at 4:15 PM the DON reported she took over the medication cart following the incident on 8/28/25 with Tenant #3 and Staff B which occurred around 4:00 PM. When she looked in the cart, she discovered Staff B had administered the 8:00 PM medication to about half of the tenants. This was outside of the approved time parameters according to the DON. The DON was unable to provide the names of the tenants who received their medication early on 8/28/25. The DON confirmed tenants did not receive medication as ordered by their medical providers.	