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

Date: June 12, 2026
Program Name: Meadowview Memory Care Village
Address: 3005 F Ave NW, Cedar Rapids, IA 52405
Type of Action: Investigations #131197-I, 131496+I, 131776-I, 131879-I, 132108-I, 131877-C, & 130915-C
Date(s) of Action: 5/11/26 – 5/14/26
Citation #11156

State Rule #		Amount of Civil Penalty
Iowa Administrative Code 481 Chapter 67.3(2)	**481-67.3(231B,231C,231D) Tenant rights. All tenants have the following rights:** **67.3(2) To receive care, treatment and services that are adequate and appropriate.** Based on observation, interview and record review, the Program failed to provide treatment that was adequate and appropriate to 1 of 7 tenants (Tenant C2). Findings follow: Record review on 5/13/26 showed Tenant C2 was admitted on 9/26/25 with a diagnosis of depression, hyperlipidemia, diabetes, prostatic hyperplasia with urinary tract symptoms, hearing loss, anemia, chronic embolism and thrombosis of deep veins of lower extremities, chronic kidney disease, dementia with agitation, long term anticoagulant usage, paroxysmal atrial fibrillation, chronic pancreatitis, muscle weakness, rheumatic mitral valve disease, heart failure, and hypersomnia. Tenant C2's service plan dated 1/15/26 showed Tenant C2 had a global deterioration score (GDS) of 5 which indicated he had moderately severe cognitive decline. The service plan showed Tenant C2 required staff assistance with bathing, hygiene and grooming, dressing and undressing, ambulation, continence, meal preparation, and medication administration. Tenant C2 required continence checks at 12:00 a.m. and 4:00 a.m. during the overnights. Tenant C2 required staff to complete safety checks hourly, 24 hours a day. A review of Tenant C2's incident reports revealed a fall dated 4/01/26 at 5:00 a.m. Tenant C2 was discovered by staff at the 5:00 a.m. safety rounds on the floor of his apartment sitting against his bed. Tenant appeared to have no injuries and was assisted to his	**$3000.00**

	bed with two staff. Tenant C2 complained of no injuries. Tenant C2 was found on the floor a second time that morning at 7:00 a.m. Nurse's notes dated 4/01/26 at 12:15 p.m., Tenant C2 displayed increased shakiness, difficulty understanding directions, increased urination, and increased falls. Tenant C2's family was called and he was taken to the emergency room for evaluation. A hospital report dated 4/1/26 revealed Tenant C2 was admitted for increased falls. Hospital records showed a urinalysis was negative and no acute findings in the chest, abdomen, or pelvis. Tenant C2 had a L2 moderate to severe compression fracture with approximately 5 mm of retropulsion with sclerosis of the superior endplate and new from 2025. Physician noted discussions with family to consider palative care. Tenant C2's continence assistance data for 4/01/26 during the hours of 12:00 a.m. and 4:00 a.m. were not completed. Tenant C2's safety check data for the overnight shift starting on 3/31/26 into 4/01/26 revealed no safety checks were documented as being completed between 9:37 p.m. on 3/31/26 through 6:38 a.m. on 4/01/26. When interviewed on 5/13/26 at 11:30 a.m., a family member of Tenant C2 shared a screenshot of Tenant C2's fall on 4/01/26. Although Tenant C2 was found in his room at 5:00 a.m. by staff the screenshot showed Tenant C2 fell at 2:13 a.m. and remained on the floor until found at 5:00 a.m. When interviewed on 5/13/26 at 5:46 p.m., Staff F confirmed she worked the overnight on 3/31/26 into 4/01/26. Staff F stated she arrived to work at 10:00 p.m., received report from the previous shift and then worked the first 30 minutes of the shift alone until another staff arrived, Staff G. Staff F reported the third staff member failed to come to work that night. The two staff members each were in charge of one hall and she had the hall Tenant C2 was not on. Staff F only saw Tenant C2 after he was found on the floor at 5:00 a.m. Staff F stated she assessed Tenant C2 and took his vitals after he was found. Staff F recalled staying with Tenant C2 until around 6:30 a.m. When interviewed on 5/13/26 at 5:59 p.m., Staff G stated she arrived after 10:00 p.m. to work the overnight shift on 3/31/26 into 4/01/26. Staff G stated the night was busy and she worked her way up the hallway to do checks on tenants. Staff G stated she believed she attempted to prompt Tenant C2 to use the restroom between 2:00 a.m. and 3:00 a.m. He refused to use the restroom. Staff G revealed she finished her rounds at around 5:00 a.m.,	

	when she found Tenant C2 on the floor of his apartment. His walker was close to him, he had one shoe off, and his depends and pants were off. Staff G believed he must have attempted to use the restroom. Staff G reported her walkie-talkie was broken and so she went to find Staff F for assistance. Together they assisted Tenant C2 off the floor and changed his clothing. Staff G gave him some cereal to to eat. Staff G confirmed she was trained on completing toileting and safety checks on tenants but it was a busy night and one staff failed to show up to their shift. Review of the entrance form completed by the Program administration on 5/12/26, showed the overnight shift was to have 3 staff members present. When interviewed on 5/14/26 at 2:20 p.m., the Director of Business Development, Administrative Assistant, and Executive Director of Campus confirmed staff failed to complete all continence assistance checks and safety checks during the overnight shift of 4/1/26.	