STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0228	A. BUILDING: _____ B. WING _____	C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW MEMORY CARE VILLAGE	3005 F AVENUE NW CEDAR RAPIDS, IA 52405

(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 visit. Number of tenants without cognitive impairment: 6 Number of tenants with cognitive impairment: 33 Total census: 39 No regulatory insufficiencies were cited during the investigation of Incident #128790-I. The following regulatory insufficiencies were cited during the investigations of Complaints #125098-C and #126308-C.	A 000	See attached POC 6/26/25	
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 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	A 160		

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A 160	Continued From page 1	A 160		

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

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A 160	Continued From page 2	A 160		

lips were blue. The RN detected no respirations or blood pressure and determined the tenant to be 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

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A 160	Continued From page 3	A 160		

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. Awhile 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

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A 160	Continued From page 4	A 160		

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.

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A 160	Continued From page 5 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.	A 160		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted	A 350		

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A 350	Continued From page 6 in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to adequately address services needs in a timely manner for 1 of 1 tenants reviewed with inappropriate sexual behavior (Tenant #7). Finding follows: On 5/20/25 at 4:40 p.m. Staff E stated Tenant #7 had sexually assaulted female tenants. She had seen him put his hand down the front of Tenant C3's pants. During a follow-up interview on 5/27/25 at 4:25 p.m. Staff E said she saw this occur twice in late 2024. She said Staff B also witnessed one or both incidents. Staff E said the incidents were reported to management staff and she thought incident reports were written. Staff E indicated Tenant #7 had sexual contact with other female tenants, who had since passed away or moved away. On 5/21/25 at 2:50 p.m. Staff B said Tenant #7 made inappropriate sexual comments to female tenants and staff. She said Tenant #7 tried to convince female tenants to come to his room. He tried to touch other tenants or have them touch him. Management staff told the staff to keep an eye on Tenant #7, but staff were unable to constantly watch him. Staff B said she witnessed	A 350		

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A 350	Continued From page 7	A 350		

Tenant #7 with his hand down the front of Tenant #C3's pants several months ago.

On 5/27/25 at 3:00 p.m. Staff F stated she saw Tenant #7 with his hand down the front of Tenant #C3's pants once or twice in the past. She said she reported the incidents to management staff. Staff were told to redirect Tenant #7.

Record review revealed Tenant #7 was an 84 year old man with a diagnosis including Alzheimer's disease and generalized anxiety disorder. His Global Deterioration Scale (GDS) score as of 5/07/25 was 4, which indicated moderate cognitive decline. Review of incident reports for 2024 revealed no documented incidents of inappropriate sexual behavior. A review of progress notes and nurse reviews also revealed no documented incidents of inappropriate sexual behavior in 2024.

Tenant #C3 was 88 years old when she passed away under hospice care on 5/16/25. Her diagnosis included Alzheimer's Disease. Her GDS score on 5/13/25 was 7, indicating the very severe cognitive decline and the highest level on the 7 point scale. Tenant C3's GDS score was 6 on 3/11/25 and 12/06/24. Record review revealed one documented incident in the past year of sexual contact with Tenant #7, on 4/08/25.

Incident reports for Tenant #7 and Tenant C3 for 4/08/25 revealed staff walked by a back room area (parlor) and saw Tenant #7 seated next to Tenant C3 with his hand down her pants. Tenant #7 quickly removed his hand when staff asked what he was doing. He told the staff they were just talking. Staff directed Tenant #7 out of the room. Tenant #7 and Tenant C3 got up and went to Tenant C3's room. Staff then directed Tenant

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A 350	Continued From page 8 #7 out of Tenant C3's room to his own room. A nurse review for Tenant #7 dated 4/10/25 reviewed the incident on 4/08/25. The review indicated Tenant #7 would be put on hourly safety checks and he and Tenant C3 should not be left alone together. Tenant #7 should be directed out of the back parlor area. The nurse review indicated the service plan was updated. Tenant #7's service plan dated 2/07/25 indicated he made inappropriate sexual statements to female staff and should be redirected. There was no other information regarding inappropriate sexual behavior. The service plan was updated on 5/07/25, almost one month after the incident on 4/08/25. The updated service plan included hourly safety checks and indicated, "Tenant to be redirected if found with a female tenant." The plan did not indicate Tenant #7 should be directed away from the back parlor. Incident reports for Tenant #7 and Tenant #2 for 5/15/25 indicated they were sitting next to each other when Tenant #7 grabbed Tenant #2's arm and put her hand on his crotch. Staff separated them. Tenant #2 was a 91 year old female with a diagnosis including anxiety disorder and age related osteoporosis. Her GDS score on 4/16/25 was 6, which indicated severe cognitive decline. A nurse review for Tenant #7 dated 5/20/25 reviewed the incident on 5/15/25. She noted Tenant #7 placed Tenant #2's hand on his genital area outside of his clothing. The nurse review indicated Tenant #7's service plan would be updated "that if (Tenant #7) is seen with female tenants to direct to room and offer privacy."	A 350		

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A 350	Continued From page 9 Tenant #7's service plan was last updated on 5/07/25 and did not include information to direct him to his room and offer privacy when seen with female tenants. On 5/21/25 at 1:45 p.m. the Registered Nurse (RN) stated she only knew of two incidents of inappropriate sexual touching between Tenant #7 other tenants: the incident with Tenant C3 on 4/08/25 and the incident with Tenant #2 on 5/15/25. The RN said Tenant #7 now had hourly checks and staff were told to patrol/check the central area and their assigned hallways. Staff should encourage Tenant #7 to stay in the central common area so they can keep an eye on him. On 5/27/25 at 3:40 p.m. the Executive Director (ED) and Licensed Practical Nurse (LPN) stated they knew only of the two recent incidents involving Tenant #7 having inappropriate sexual contact with other tenants. They said there were no prior staff reports or staff documentation of other incidents. Since the two recent incidents, staff checked on Tenant #7 hourly and redirected him as needed. On 5/28/25 at 10:30 a.m. the ED and LPN confirmed Tenant #7's service plan was last updated regarding the inappropriate sexual touch of another resident on 5/07/25, almost one month after the incident on 4/08/25. The LPN said the service plan developed on 5/07/25 included hourly checks and indicated staff should direct Tenant #7 to move away anytime he was seated next to a female tenant. When asked about the meaning of the nurse review dated 5/20/25 to redirect Tenant #7 to his room when seen with female tenants and offer privacy, the LPN said she meant staff should direct the tenant to his	A 350		

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A 350	Continued From page 10 room by himself, not with the female tenants. The LPN confirmed Tenant #7's service plan was not yet updated after the incident on 5/15/25.	A 350		

ok
7/14/25

Department of Inspections and Appeals
Attn: Catie Campbell
6200 Park Avenue Suite 100
Des Moines, Iowa 50321

Dear Ms. Campbell:

On behalf of Meadowview Memory Care Village, I respectfully submit our Plan of Correction for your approval. This response is specific to the Incident #128790-I and Complaints #125098-C and #126308-C Visit, for the onsite visit dates between 5/19/25 and 5/28/25. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the alleged facts or conclusions set forth in the statement of insufficiencies. The Plan of Correction is executed solely because it is required by the provisions of Iowa Law.

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.

1. Elements detailing how the Program will correct each regulatory insufficiency
    - Tenants shall have the right to receive care, treatment, and service which are adequate and appropriate.
2. Measures taken to ensure the problem does not recur
    - The Director of Nursing, and Nurse Designee were re-educated on tenant rights to receive care, treatment, and services which are adequate and appropriate.
    - The program staff were re-educated, regarding when to notify the program nurse.
3. How the Program plans to monitor performance to ensure compliance
    - The Director of Nursing and/or Designee will complete ongoing audits to ensure tenant's receive care, treatment, and service which are adequate and appropriate.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on or before July 26, 2025.

481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.

1. Elements detailing how the Program will correct each regulatory insufficiency
    - Tenant's service plans shall be developed for each tenant based on health, functional, and cognitive evaluations and shall be designed to meet the specific service needs of the individual tenant. The service plan shall be updated at least annually and whenever changes are needed.
    - Tenant #7's service plan was updated to reflect the specific needs of the tenant relating to inappropriate behaviors.
2. Measures taken to ensure the problem does not recur
    - The Director of Nursing, and Nurse Designee were re-educated on service plan development for each tenant based on health, functional, and cognitive evaluations to

meet the specific service needs of the individual tenant. The service plan shall be updated at least annually and whenever changes are needed.

3. How the Program plans to monitor performance to ensure compliance
    - The Director of Nursing and/or Designee will complete ongoing audits to ensure service plans meet the specific service needs of the individual tenant and service plans shall be updated at least annually and whenever changes are needed.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on or before July 26, 2025.

If you have any questions regarding this plan of correction, please contact me at 319-294-9669.

Respectfully submitted,

Bella Curtis
Executive Director