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
	S0228	A. BUILDING: _____ B. WING _____	C 10/16/2025

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. Tenants without cognitive impairment: 2 Tenants with cognitive impairment: 39 Total census: 41 The following regulatory insufficiencies were cited during the investigation of Incident #130519-I	A 000	See attached POC 2/20/2026	
A 120	481-67.2(1)c Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: c. The person in charge at the time of the incident shall prepare and sign the report. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Director of Nursing failed to complete incident reports for an unknown number of tenants when she discovered they received their medication outside of the approved time frame. Findings follow: An interview conducted with the Director of	A 120		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 120	Continued From page 1 Nursing (DON) on 10/14/25 at 4:15 PM revealed she opened the medication cart on 8/28/25 at 4:00 PM and discovered the 8:00 PM medication for half the tenants was already administered by Staff B. The DON explained medication could be administered one hour before or one hour after the scheduled time. Staff B administered the medication for tenants significantly earlier than was acceptable. The DON said she asked Staff B to document the early administration of tenants' medication, but did not ensure it was completed. Record review of a Medication Administration Audit Report dated 8/28/25 revealed no indication Staff B administered medication to tenants outside of the approved time frames. There were no incident reports written to identify medication errors for an unknown number of tenants. The DON confirmed there were no incident reports written to explain the situation on 8/28/25 during an interview on 10/16/25 at 11:30 PM.	A 120		
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.	A 285		

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A 285	Continued From page 2 This REQUIREMENT is not met as evidenced by: 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 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	A 285		

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A 285	Continued From page 3	A 285		

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

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A 285	Continued From page 4 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	A 285		

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A 285	Continued From page 5	A 285		

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

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A 285	Continued From page 6 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.	A 285		
A 345	481-67.9(4)b Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: b. Within 30 days of beginning employment, all program staff shall receive training by the	A 345		

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A 345	Continued From page 7 program's registered nurse(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review, there was evidence the program failed to ensure staff hired through a staffing agency were adequately trained in administering medication within 30 days of employment for 6 of 7 staff reviewed (Staff C, Staff D, Staff E, Staff F, Staff G and Staff H). Findings follow: Record review on 10/15/25 revealed Staff C was hired to work at the program through a temporary staffing agency on 5/8/25. She was delegated by the Director of Nursing (DON) on 10/9/25. Staff D was hired to work at the program through a staffing agency on 9/28/24. She was delegated by the DON on 10/8/25. Staff E was hired to work at the program through a staffing agency on 5/2/25. She was delegated by the DON on 10/14/25. Staff F was hired to work at the program through a staffing agency on 12/30/24. She was delegated by the DON on 10/14/25. Staff G was hired to work at the program through a staffing agency on 6/4/25. She was delegated by the DON on 10/14/25. Staff H was hired to work at the program through a staffing agency on 9/3/25. She was delegated by the DON on 10/7/25. During an interview on 10/13/25 at 3:05 PM the DON reported staff received a general orientation	A 345		

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A 345	Continued From page 8 at the time of hire but were not delegated on all tasks until 10/25.	A 345		

On behalf of Meadowview Memory Care Village in Cedar Rapids, Iowa, I respectfully submit our Plan of Correction for your approval. This response is specific to Incident 130519-I investigated from 10/13/25-10/16/25.

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.

Policies and Procedures

1. Elements detailing how the program will correct each regulatory insufficiency
    - Incident reports will be completed when medications administered by the program are not administered within the delegated time frame of administration or administered as ordered by the physician.
2. Measures taken to ensure the problem does not recur
    - Staff will be re-educated on completing incident reports for medication errors, including medications not administered during the time frame specified.
3. How the Program plans to monitor performance to ensure compliance
    - The Director of Nursing, and/or Nurse Designee will provide ongoing education to staff at least annually on the accident, incident, and medication error reporting policy.
    - The Director of Nursing, and/or Nurse Designee will monthly complete audits to ensure medications are administered during the delegated time frame scheduled.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on February 20, 2026

Medications

1. Elements detailing how the program will correct each regulatory insufficiency
    - Medications that are delegated to the program will be administered as ordered by their provider.
    - Medications administered by the program will be administered using the 6 rights of medication administration.
2. Measure taken to ensure the problem does not recur
    - Staff will be re-educated on medication administration including the 6 rights of medications administration.

- Staff will be re-educated on crushing medications
- Staff will be re-educated on observing the tenant swallowing all of medications before leaving the tenant

3. How the Program plans to monitor performance to ensure compliance
    - The Director of Nursing and/or Nurse Designee will provide on-going education to staff annually on medication administration.
    - The Director of Nursing and/or Nurse Designee will perform monthly medication administration audits of staff certified to administer medications.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on February 20, 2026

Staffing

1. Elements detailing how the program will correct each regulatory insufficiency
    - Staff hired through a staffing agency will be delegated by the programs delegating nurse within 30 days of employment.
    - All Meadowview staff and agency staff have been re-delegated by the programs registered nurse.
2. Measure taken to ensure the problem does not recur
    - The Director of Nursing and/or Nurse Designee will be re-educated on Nurse Delegation procedures including delegation for agency staff members to be completed within 30-day of employment.
3. How the Program plans to monitor performance to ensure compliance
    - The program will complete monthly audits of delegations of agency staff to ensure completion of delegations within 30 days of employment.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on February 20, 2026.