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 05/14/2026

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: 1 Tenants with cognitive impairment: 46 Total census: 47 No regulatory insufficiencies were cited during the investigation of Incident #131776-I and Incident #132108-I. Regulatory insufficiencies were cited during the investigation of Incident #131197-I, Incident #131496-I, Incident #131879-I, Complaint #131877-C, and Complaint #130915-C.	A 000	See attached POC 7/12/26	
A 116	481-67.2(2) Program Policies and Procedures 67.2(2) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to follow policies related to narcotic medication administration and incident reporting for 2 of 7 tenants reviewed (Tenant #1, Tenant C2). Findings follow: 1. Record review on 5/12/26 for Tenant #1 revealed an incident report dated 1/1/26. The incident report showed Tenant #1 had a Lorazepam 0.5 mg tablet missing from her	A 116		

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

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 05/14/2026

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 116	Continued From page 1	A 116		

narcotic count at the 10:00 p.m. The incident report further revealed the narcotic count was accurate during the previous count at 2:00 p.m. Staff searched the medication cart but the tablet was not located. The Executive Director and the Director of Nursing were notified. The incident report indicated interviews with staff revealed Staff A stated the medication was knocked off the medication cart during her medication pass and she destroyed the medication because it fell on the floor. Staff A admitted she failed to destroy the medication properly and she failed to notify the nurse regarding the destruction of the medication.

Tenant #1's medication administration record for January 2026, revealed Tenant #1 took the Lorazepam 0.5 mg twice daily at 8:00 a.m. and 7:00 p.m.

Tenant #1's controlled substance count and usage record for her Lorazepam 0.5 mg tablet showed the following recording:
1/01/26 at 2:00 p.m. there were 9 tablets available, none administered.
1/01/26 at 7:00 p.m. there were 9 tablets available, one tablet administered at 7:00 p.m., which left 8 tablets remaining.
1/01/26 at 10:00 p.m. there were 7 tablets available, none administered at that time.
The 10:00 p.m. narcotic count was missing one tablet of Lorezepam 0.5 mg.

When interviewed on 5/13/26 at 3:50 p.m., the Assistant Director of Nursing revealed she was informed by Staff J, Tenant #1's narcotic count for Lorazepam 0.5 mg was off by one tablet. Staff J reported the count at 2:00 p.m. and 7:00 p.m. were correct. The Assistant Director of Nursing discovered later, Staff A told her she had used an

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 05/14/2026

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 116	Continued From page 2	A 116		

extra tablet of the 0.5 mg Lorazepam when the pill she was going to give at 7:00 p.m. on 1/01/26 was knocked to the floor. Staff A told her she threw the pill away.

When interviewed on 5/12/26 at 4:04 p.m., Staff A admitted she completed narcotic counts on 1/01/26 at 2:00 p.m. with Staff H and at 10:00 p.m. with Staff J. Staff A reported when the count was off at 10:00 p.m., she had not realized it was because of her. Staff A reported at 7:00 p.m., she was in the dining room alone and prepared Tenant #1's 0.5 mg Lorazepam for her in a medication cup. Staff A noted a different tenant began to get up out of her chair and was unsteady. Staff A ran to get to her. When Staff A ran she dropped the medication cup with the Lorazepam in it on the floor. Staff A stated she threw the Lorazepam tablet away in the trash and took a new tablet out of the medication card and dispensed it to Tenant #1. Staff A confirmed she failed to notify the nurse of the medication error and failed to have another medication manager watch her destroy the medication.

A review of policies on 5/14/26 revealed a Narcotic Medication Management policy. The policy revealed the following procedure: Disposal of narcotic medications must be witnessed by two certified medication managers. Staff to refer to the Drug Disposal Policy for proper disposal.
The Drug Disposal Policy revealed the following procedures:
a. Inform the nurse or nurse on-call that some medications need disposed/destructed.
b. If staff were instructed to destroy a medication, the medication was placed in the container of Drug Buster.

When interviewed on 5/14/26 at 2:20 p.m., the

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 05/14/2026

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 116	Continued From page 3 Director of Business Development, Administrative Assistant, and Executive Director of Campus confirmed Staff A failed to follow the Program's Narcotic Medication Policy. 2. Record review on 5/13/26, revealed Tenant C2 had an incident report dated 3/18/26 on file. The incident report revealed Tenant C2 was discovered on the floor of a different tenant's apartment with no injuries. The incident report contained no time the incident occurred. The incident report revealed Staff E completed the report but had not discovered Tenant C2 on the floor. The incident report failed to include a witness statement of the staff that discovered Tenant C2 on the floor. Further review of Tenant C2's record revealed a nurse's note dated 3/23/26 at 1:23 p.m. The nurse's note revealed Tenant C2 had a wound to his right forearm with no redness or drainage. Area was cleansed and dressing applied. No incident report was in Tenant C2's record for this wound. When interviewed on 5/13/26 at 5:41 p.m., Staff E confirmed she completed the incident report for Tenant C2 being discovered on the floor on 3/18/26 but was not the staff who found him. Staff E stated she could not recall what time exactly the event occurred but thought around 2:00 a.m. On 5/14/26 the Program's policy titled Accident, Incident, and Medication Error Reporting policy was reviewed. The policy provided the following guidance: a. Staff will document all unusual accidents and incidents of tenants on an incident report form. b. The incident report shall be in detail.	A 116		

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 05/14/2026

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 116	Continued From page 4 c. The incident report shall include statements from individuals who witnessed the incident. 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 follow the Program's policy on Accidents, Incidents, and Medication Error Reporting. Staff failed to provide the detail of what time Tenant C2's 3/18/26 fall occurred or include a witness statement of the staff that discovered the tenant on the floor. Staff also failed to complete an incident report regarding Tenant C2's arm wound discovered on 3/23/26.	A 116		
A 122	481-67.3(2) Tenant Rights 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. This REQUIREMENT is not met as evidenced by: 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	A 122		

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 05/14/2026

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 122	Continued From page 5 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 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.	A 122		

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 05/14/2026

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 122	Continued From page 6 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	A 122		

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 05/14/2026

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 122	Continued From page 7 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.	A 122		
A 276	481-69.25(1)q Tenant Document 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and include: q. When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are	A 276		

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 05/14/2026

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 276	Continued From page 8 doctor-ordered, the tasks will be part of the medication administration records (MARs); This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to complete accurate documentation of routine personal or health-related cares on task sheets for 2 out of 7 tenants (Tenant #2, Tenant C4). Findings follow: 1. Record review on 5/12/26 revealed an incident report dated 1/30/26 for Tenant #2. On 1/30/26 at 7:21 p.m., Tenant #2 was discovered laying in front of her toilet. Tenant #2's service plan dated 1/8/26 revealed Tenant #2 required routine safety checks every hour. A review of Tenant #2's safety check data sheets for 1/30/26 revealed gaps in documentation at the following times: 6:00 p.m., 7:00 p.m., and 8:00 p.m. When interviewed on 5/13/26 at 3:01 p.m., Staff C confirmed she conducted all of her safety checks. Staff C added she knew the importance of always doing her checks for the tenants safety. 2. Record review on 5/13/26 revealed an incident report dated 12/26/25 for Tenant C4. On 12/26/25 at 4:30 a.m., Tenant C4 was seen falling in the hallway and subsequently hit her head on the wall. Tenant C4's service plan dated 9/05/25 revealed Tenant C4 required routine safety checks every hour. A review of Tenant C4's safety check data sheets for 12/26/25 revealed gaps in documentation at the following times: 6:00 a.m., 7:00 a.m., and 9:00 a.m., and 10:00 a.m. When interviewed on 5/14/26 at 1:40 p.m., Staff I confirmed Tenant C4 was taken to her bed after	A 276		

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 05/14/2026

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 276	Continued From page 9 her fall and attended to regularly. Staff I wanted to send Tenant C4 to the hospital for assessment but her guardian refused to have her sent out. Staff I stated between her and other staff, Tenant C4 definitely received safety checks as they were consistently in her room to check on her and attempt vitals. Staff had to have forgotten to document the checks. 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 document all safety checks for Tenant #2 on 1/30/26 and for Tenant C4 on 12/26/25.	A 276		
A 286	481-69.26(4)b Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and indicate: b. Any services and care to be provided pursuant to the occupancy agreement; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to include all services and care to be provided pursuant to the occupancy agreement for 1 out of 7 tenants reviewed (Tenant C2). Findings follow: Record review on 5/13/26, revealed Tenant C2's occupancy agreement dated 8/26/25 revealed the following occupancy requirement: Administration must be made aware of any cameras or	A 286		

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 05/14/2026

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 286	Continued From page 10 recording devices used in a tenant's apartment prior to installation. The tenant's service plan will identify a camera or video device in use. Tenant C2's service plans dated 1/15/26 and 3/31/26 both failed to include information regarding the camera that was in Tenant C2's room. When interviewed on 5/13/26 at 3:01 p.m., Staff C stated Tenant C2 had a camera device that sat in his window sill to record activities by staff and the tenant. When interviewed on 5/14/26 at 2:20 p.m., the Director of Business Development, Administrative Assistant, and Executive Director of Campus confirmed the Program failed to address Tenant C2's camera the family placed in is apartment on his service plan.	A 286		

Department of Inspections and Appeals
Attn: Catie Campbell
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319

Dear Ms. Campbell:

On behalf of Meadowview Memory Care in Cedar Rapids, Iowa, I respectfully submit our Plan of Correction for your approval. This response is specific to Investigations #131197-I, #131496-I, #131776-I, #131879-I, #1312108-I, #131877-C, and #130915-C. 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.
    - All medication managers were re-educated on program Narcotic Medication Management and Drug Disposal Policies.
    - All staff were re-educated on program Accident, Incident, and Medication Error Policy.
2. Measures taken to ensure the problem does not recur.
    - All staff responsible for administration of controlled substances will be trained according to the policy by the DON or ADON upon hire.
    - Director or DON will ensure all staff who witness accident or incident will complete incident report or witness statement as applicable with necessary details.
3. How the Program plans to monitor performance to ensure compliance.
    - The DON or designee will perform random, routine controlled substance audits at least weekly to ensure compliance with the policy.
    - Education will be provided upon hire, as needed and at least annually for all staff on incident reports.
4. The date by which the regulatory insufficiency will be corrected.
    - The regulatory insufficiency will be corrected on or before July 12, 2026.

Tenant Rights

1. Elements detailing how the program will correct each regulatory insufficiency.
    - Tenant C2 no longer resides in the program.
    - All tenants will receive care, treatment, and services that are adequate and appropriate.
2. Measures taken to ensure the problem does not recur.
    - All staff were re-educated on Tenant Rights.
3. How the Program plans to monitor performance to ensure compliance.
    - Staff will be provided education on Tenant Rights upon hire, as needed, and at least annually.

- Director, DON, or designee will perform random, routine night shift audits at least monthly to ensure tenant needs are being met.

4. The date by which the regulatory insufficiency will be corrected.
    - The regulatory insufficiency will be corrected on or before July 12, 2026.

Tenant Documents

1. Elements detailing how the program will correct each regulatory insufficiency.
    - All staff were re-educated on task documentation.
2. Measures taken to ensure the problem does not recur.
    - All staff were re-educated if task documentation unable to be completed, Director or DON need to be notified immediately.
3. How the Program plans to monitor performance to ensure compliance.
    - Director or DON will perform routine audits at least weekly of task documentation.
    - Education on task documentation will be completed upon hire, as needed and at least annually by the DON or designee.
4. The date by which the regulatory insufficiency will be corrected.
    - The regulatory insufficiency will be corrected on or before July 12, 2026.

Service Plan

1. Elements detailing how the program will correct each regulatory insufficiency.
    - Tenant C2 no longer resides in the program.
    - Any recording devices or cameras will be identified on the Service Plan.
2. Measures taken to ensure the problem does not recur.
    - DON and ADON were re-educated on Service Plans.
3. How the Program plans to monitor performance to ensure compliance.
    - DON or designee will perform audits of the Service Plans at least quarterly to monitor for compliance and completeness including cameras/recording devices.
4. The date by which the regulatory insufficiency will be corrected.
    - The regulatory insufficiency will be corrected on or before July 12, 2026.

If you have any questions regarding this Plan of Correction, please contact me at (319) 294-9669.

Respectfully submitted,

Bella Curtis, Assisted Living Director