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
	S0474	A. BUILDING: _____ B. WING _____	C 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW OF CLIVE MC	3300 BERKSHIRE PARKWAY CLIVE, IA 50325

(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: 0 Tenants with cognitive impairment: 11 Total census: 11 No regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program. The following regulatory insufficiencies were cited during the investigation of Incident 131123-I, Complaints #131121-C & 131134-C.	A 000	A250 – 481-69.24(1)(a) Involuntary Transfer Deficiency: The facility failed to ensure an involuntary transfer notification contained accurate contact information for the Office of the Long-Term Care Ombudsman. 1. Corrective Action for Resident Affected The involuntary transfer notice for Tenant C4 was reviewed. The facility verified the current and correct contact information for the Office of the Long-Term Care Ombudsman and updated to reflect the accurate information. Tenant C4 has since been discharged. 2. Identification of Other Residents Potentially Affected The Executive Director completed an audit of involuntary transfer/discharge notices issued within the previous 6 months to determine whether accurate Long-Term Care Ombudsman contact information was included. No additional tenants were involuntarily discharged within the last 6 months.	
A 250	481-69.24(1)a Involuntary Transfer 481-69.24(231C) Involuntary transfer from the program. 69.24(1)Program initiation of transfer. The program shall comply with Iowa Code section 231C.6 and the following: a. The program will provide the tenant, or the tenant's legal representative, the contact information for the office of long-term care ombudsman. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 250	3. Systemic Changes The facility reviewed its involuntary transfer/discharge procedure to require verification of the current Office of the Long-Term Care Ombudsman contact information before any involuntary transfer notice is issued. The involuntary transfer notice template was revised to include the correct Ombudsman contact information. The Executive Director/Director of Health Services responsible for resident transfer/discharge processes received education regarding Iowa Administrative Code 481-69.24(1)(a) requirements on July 10th, 2026.	

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A 250	Continued From page 1 Program failed to consistently ensure involuntary transfer notifications contained the required information. This pertained to 1 of 1 tenant (Tenant C4) who received an involuntary transfer notice. Finding follows: Record review on 6/2/26 revealed a document provided by the Program addressed to Tenant C4 and her family. The document noted the tenant was being provided immediate notice of termination of her contract, effective 12/26/25, due to safety concerns. Further review revealed the Program provided incorrect contact information for the long-term care ombudsman. During exit on 6/2/26 at 4:15 p.m. the administrative team acknowledged the involuntary transfer notice provided inaccurate information.	A 250	4. Monitoring The Executive Director or designee will audit 100% of involuntary transfer/discharge notices issued for a period of six months to verify inclusion of accurate Long-Term Care Ombudsman contact information through the Quality Assurance/Performance Improvement process. Corrective action will be implemented immediately if concerns are identified. Completion Date: August 2, 2026	
A 251	481-69.24(1)b Involuntary Transfer 481-69.24(231C) Involuntary transfer from the program. 69.24(1)Program initiation of transfer. The program shall comply with Iowa Code section 231C.6 and the following: b. The program will immediately provide to the office of long-term care ombudsman, by mail or email, a copy of the notification and notify the tenant's treating physician, if any. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 251		

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A 251	Continued From page 2 Program failed to consistently provide immediate notice of involuntary transfer notice as required. This pertained to 1 of 1 tenant (Tenant C4) who received an involuntary transfer notice. Finding follows: Record review on 6/2/26 revealed a document provided by the Program addressed to Tenant C4 and her family. The document noted the tenant was being provided immediate notice of termination of her contract, effective 12/26/25, due to safety concerns. Further review revealed the Program provided incorrect contact information for the long-term care ombudsman. During an interview on 6/2/25 at 11:10 a.m. with the Long-Term Care Ombudsman confirmed the Program failed to immediately provide notification to the office of the Long-Term Care Ombudsman. She explained the Program provided notice on 12/31/25 after she requested the notice. The notice was dated 12/30/25 and the Program listed the date of termination for Tenant C4 as 12/26/25. During exit on 6/2/26 at 4:15 p.m. the administrative team acknowledged the involuntary transfer notice had not been provided immediately to the Long-Term Care Ombudsman.	A 251	A251 – 481-69.24(1)(b) Involuntary Transfer Deficiency: The facility failed to immediately provide the Office of the Long-Term Care Ombudsman with a copy of the involuntary transfer notification. 1. Corrective Action for Resident Affected The facility reviewed the involuntary transfer process related to Tenant C4 and confirmed notification requirements. The Ombudsman's office was contacted via email same day and certified mail next day. Tenant C4 has since been discharged. 2. Identification of Other Residents Potentially Affected The Executive Director completed a review of involuntary transfer/discharge events occurring during the previous 12 months to determine whether notification to the Office of the Long-Term Care Ombudsman was completed timely and documented. No additional tenants were involuntarily discharged within the last 6 months. 3. Systemic Changes The facility reviewed its involuntary transfer/discharge procedure to require notification to the Office of the Long-Term Care Ombudsman immediately upon issuance of an involuntary transfer notice. Cassia Policy matches Iowa Regulation. Education provided to the Executive Director and Director of Health Services responsible for transfer/discharge activities regarding Iowa Administrative Code 481-69.24(1)(b) requirements on July 10th, 2026. 4. Monitoring The Executive Director or designee will audit 100% of involuntary transfer/discharge notices for six months to ensure appropriate contact information of the Office of the Long-Term Care Ombudsman. Audit findings will be reviewed monthly through the facility's Quality Assurance process. Any identified variances will result in re-education and corrective action. Completion Date: August 2, 2026	