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
	S0459	A. BUILDING: _____ B. WING _____	C 01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW OF JOHNSTON MC	5555 PIONEER PARKWAY JOHNSTON, IA 50131

(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: 6 Tenants with cognitive impairment: 9 Total census: 15 The following regulatory insufficiencies were cited during the investigation of Incident #131057-M and #131172-A.	A 000	see attached POC 5/5/26	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) 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 established policy and procedures regarding the expectation for reassurance checks for memory care tenants for 1 of 5 memory care tenants reviewed (Tenant #C1). Finding follows: On 12/12/25, the Program self-reported an incident involving Tenant #C1 on 12/05/25. Tenant #C1 took herself to the toilet around 2:00 a.m. on 12/05/25. Staff A responded to Tenant #C1's room motion detection system, observed Tenant #C1 on the toilet, reset the motion detection system, and exited the room per the tenant's routine behavior and history of being able to take herself to the toilet and being independently mobile and ambulatory.	A 150		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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
	S0459	A. BUILDING: _____ B. WING _____	C 01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW OF JOHNSTON MC	5555 PIONEER PARKWAY JOHNSTON, IA 50131

(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 150	Continued From page 1 A progress note dated 12/05/25 noted the Licensed Practical Nurse (LPN)/AssistantDirector of Health Services (nurse) was called to Tenant #C1's room and Tenant #C1 was seated on the toilet and voiced complaints of pain. Tenant #C1 complained she couldn't stand and the back of her legs hurt. Tenant #C1 showed increased cognitive concerns and engaged in repetitive questioning. The nurse indicated redness to the back of thighs from the toilet seat, but no other injuries. The nurse and Program staff assisted Tenant #C1 from the bathroom, and Tenant #C1t ambulated with a bent over and slow gait with a walker. The nurse placed a call to the son of Tenant #C1 and suggested Tenant #C1 be further evaluated by her Primary Care Physician (PCP). During an interview on 1/13/26 at 10:45 a.m. with the LPN/Assistant Director of Health Services, reported she was called to Tenant #C1's room by direct care staff around 8:30 a.m. or 9:00 a.m. as Tenant #C1 wasn't acting right and confirmed by the progress note documentation. The nurse indicated she questioned Tenant #C1 on the day of the incident on how long she had been sitting on the toilet and Tenant #C1 replied "not very long." A few hours later Tenant #C1's son arrived to provide transportation to the PCP appointment, when the nurse was again called to the room after requesting 911 be called. When emergency personnel arrived to assist with the transport, Tenant #C1's son informed the nurse the tenant complained of pain because she sat on the toilet for six hours, she sat on the toilet since 2:00 a.m., and no one entered the room until 8:30 a.m. per the son's review of the Ring camera system in place in the room as provided by the tenant's family. The Program began an internal investigation. When questioned about the	A 150		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0459	A. BUILDING: _____ B. WING _____	C 01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW OF JOHNSTON MC	5555 PIONEER PARKWAY JOHNSTON, IA 50131

(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 150	Continued From page 2	A 150		

Program's expectation for reassurance/safety checks, the nurse stated the expectation was for checks to be completed every two hours, but it was a general expectation, not necessarily identified on each tenant's service plan.

Record review on 1/12/26 revealed Tenant #C1 admitted to the Program on 6/01/23 and diagnoses included: unspecified dementia, hypothyroidism, essential hypertension, anxiety disorder, osteoarthritis, chronic obstructive pulmonary disease, edema, other disorders of the urinary system, and repeated falls.

Tenant #C1 experienced a change of condition and moved to the memory care unit on 10/23/25. A comprehensive assessment, dated 11/06/25 noted a change of condition assessment due to higher level of care/move to memory care, identified Tenant #C1 was independent with toileting needs, independent with mobility and transfer needs with use of a four-wheeled walker, independent with the use of the operating summoning system, and required a reassurance check daily in the A.M.

A service plan, signed and dated by parties 11/04/25 failed to address Tenant #C1's independence with toileting, independence with mobility/ambulation with use of a four-wheeled walker, and the need for reassurance checks.

A progress note dated 11/06/25 noted the change of condition assessment and move to memory care indicated "continue current plan of care. Service agreement is up to date." (referred to the 10/23/25 created service plan, signed by parties 11/04/25.)

An incident report dated 11/12/25 noted a fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0459	A. BUILDING: _____ B. WING _____	C 01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW OF JOHNSTON MC	5555 PIONEER PARKWAY JOHNSTON, IA 50131

(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 150	Continued From page 3	A 150		

occurred on 11/11/25 and indicated a fall reduction plan was in place which included "reassurance checks to assist her with cares." As part of the incident follow-up, the service plan was revised and new fall reduction intervention was implemented listed as "time of cares adjusted".

A service plan dated 12/07/25 (print date at top of document) failed to address Tenant #C1's independence with toileting, independence with mobility/ambulation with use of a four-wheeled walker, failed to identify the required AM reassurance check, but now identified a reassurance check with an effective date of 11/12/25, and identified the check was to be completed nightly at 10:30 p.m., and instructed staff to "please assist (Tenant #C1) into her pjs after the news. Ensure she has her pjs (pajamas) on, dentures brushed and soaking. Face-to-face check on resident status."

A review on 1/12/26 of the Program's policy entitled "Direct Care Staffing - AL-IA", dated 12/03/25, included the following: "Memory care staff will round on residents every 2 hours. If a tenant with dementia is unable to activate the pendant system, the RN coordinator will address needs individually on the service plan."

During a tour of the memory care unit on 1/14/26 at 1:00 p.m. and follow-up interview with the LPN/Assistant Director of Health Services, indicated no memory care tenants wore summoning pendants in memory care, there were no pull cord systems in the tenant bathrooms, staff were expected to conduct the reassurance checks and some tenants required checks based on their individual needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0459	A. BUILDING: _____ B. WING _____	C 01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW OF JOHNSTON MC	5555 PIONEER PARKWAY JOHNSTON, IA 50131

(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 150	Continued From page 4 During an interview with Staff A on 1/14/26 reported Tenant #C1 was independent with toileting and mobility/ambulation/transfers. She took herself to the bathroom and returned on her own to bed. She recalled responding to the motion detection system around 2:00 a.m., saw Tenant #C1 on the toilet, and exited the room, per the normal routine. When questioned about any routine reassurance checks for Tenant #C1, Staff A indicated the ADL task documentation system would display a list of tenant names which required checks on certain hours and list additional individual tasks or instructions for each of those tenants during those specific reassurance checks, but Tenant #C1's name was not listed as needing routine checks throughout the overnight shift. Staff A recalled she performed the reassurance checks on 12/05/25 for the individual tenants as identified on the tenant list in the ADL task documentation system and as identified per the training she received. During an interview on 1/12/26, Staff B indicated Tenant #C1 was able to ambulate on her own, could get up and down on her own, and toilet herself. During an interview on 1/13/26, Staff C reported Tenant #C1 was independently ambulatory and could take herself to the bathroom. Following the incident with Tenant #C1 on 12/05/25, Staff C recalled being educated on the reassurance checks, and believed dayshift checks were expected to be completed every hour, but was unsure of what the expectation was for the overnight shift. During an interview on 1/14/26, Staff D indicated Tenant #C1 could take herself to the bathroom okay without assistance and walk independently.	A 150		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0459	A. BUILDING: _____ B. WING _____	C 01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW OF JOHNSTON MC	5555 PIONEER PARKWAY JOHNSTON, IA 50131

(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 150	Continued From page 5	A 150		

Staff D could not recall seeing Tenant #C1's name on the list of tenants who required routine reassurance checks at the time of the incident, but confirmed the task documentation system currently displayed checks were to be completed on all tenants.

During an interview on 1/14/26, Staff E reported Tenant #C1 was able to get up and go to the restroom on her own and back to bed. Staff E explained the reassurance task documentation system would display a list of tenant names to check on, but didn't recall Tenant #C1's name as well additional other tenant names being on the list as needing routine overnight reassurance checks on the date of the incident. Staff E confirmed the system was changed after the incident and now reflected reassurance checks were to be completed on all memory care tenants.

During an interview on 1/13/26, the RN Director of Health Services (RN) indicated the Program was informed (unknown date) by Tenant #C1's family following the incident, Tenant #C1 developed Rhabdomyolysis from sitting on the toilet for six hours. The RN stated the Program attempted to obtain medical records both from the hospital as well as with requests to Tenant #C1's family, but no medical documentation was ever provided. The Program was informed by the tenant's family on 12/08/25 the tenant would be transferred from the hospital to a hospice house and the family didn't expect Tenant #C1 would live many more days. The tenant later passed away at the hospice house on 12/24/25. A copy of Tenant #C1's death certificate obtained at the time of the onsite visit listed Tenant #C1's cause of death as "metabolic complications due to rhabdomyolysis" due to or as a consequence of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0459	A. BUILDING: _____ B. WING _____	C 01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW OF JOHNSTON MC	5555 PIONEER PARKWAY JOHNSTON, IA 50131

(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 150	Continued From page 6	A 150		

"prolonged immobilization on commode", with "dementia, frailty of advanced age" listed as an other significant condition and "accident" listed as the manner of death. While an autopsy was not performed but listed the description of injury as "12/5/25 sat on toilet stool for over 6 (six) hours, unable to get up on own."The RN reported the Program's electronic documentation system showed two different formats for the reassurance checks. One set of reassurance checks were listed for specific tenants, while other checks listed under a general task documentation sheet, and acknowledged she hadn't entered any additional checks for Tenant #C1, as she felt these checks were across the board checks for all tenants, but acknowledged the system would display in the staff's work phones as a list of tenant names which required checks during certain hours. She indicated this was confusing for staff, and following the Program's internal investigation, she revised the wording of the tasks in the electronic charting system to reflect routine reassurance checks were to be completed for all tenants.

During a follow-up interview on 1/15/26 at 9:30 a.m. the RN Director of Health Services confirmed the two dated service plans for Tenant #C1 in comparison with the comprehensive evaluation. The RN stated all ADL tasks, including reassurance checks, were manually entered into the system and did not directly transfer over directly from a tenant's service plan. The RN confirmed she revised the wording of the reassurance checks for all tenants on 12/16/25.

Review of the ADL task documentation for Tenant #C1 as well as the general task documentation for 12/04/25 to 12/05/25 revealed Staff A completed all required tasks and reassurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0459	A. BUILDING: _____ B. WING _____	C 01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW OF JOHNSTON MC	5555 PIONEER PARKWAY JOHNSTON, IA 50131

(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 150	Continued From page 7	A 150		

checks as they were entered on each list. It noted the wording of the reassurance checks was revised on 12/16/25 to reflect reassurance checks were to be completed on all tenants.

Following the above staff interviews and confirmation by the LPN Assistant Director of Health Services which confirmed memory care tenants did not utilize call pendants, the Program's Direct Care Staffing policy and verbiage regarding "If a tenant with dementia is unable to activate the pendant system, the RN Coordinator will address needs individually on the service plan."

During a follow-up interview on 1/21/26 the LPN Assistant Director of Health Services on 1/21/26, confirmed Tenant #C1's nightly reassurance check at 10:30 p.m. had been entered/revised as a fall intervention effective 11/12/25, not in response to the Program's policy regarding routine checks in memory care.

No further individualized routine reassurance checks were identified on the service plan for Tenant #C1 in relation to the Program's policy and in comparison with other memory care tenants' individualized service plans reviewed. Staff A followed Tenant #C1's service plan in place at the time of the 12/05/25 incident. The Program failed to address needs individually on Tenant #C1's service plan in regards to the Program's expectation of routine two-hour checks per the Program policy.

On 1/20/26 at 11:50 a.m. the Executive Director confirmed the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0459	A. BUILDING: _____ B. WING _____	C 01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW OF JOHNSTON MC	5555 PIONEER PARKWAY JOHNSTON, IA 50131

(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 350	Continued From page 8	A 350		
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 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 develop a service plan which adequately addressed tenant needs based on the evaluation for 1 of 5 memory care tenants reviewed (Tenant #C1). Finding follows: Record review on 1/12/26 revealed Tenant #C1 admitted to the Program on 6/01/23, and moved to the memory care unit on 10/23/25. A comprehensive assessment, dated 11/06/25 and noted a change of condition assessment due to higher level of care/move to memory care, identified Tenant #C1 was independent with toileting needs, independent with mobility and ambulation needs with use of a four-wheeled walker, and required reassurance checks daily in the A.M. A service plan created 10/23/25, signed and dated by parties 11/04/25 failed to address Tenant #C1's independence with toileting, mobility/ambulation with use of a four-wheeled walker, and the need for reassurance checks.	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0459	A. BUILDING: _____ B. WING _____	C 01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW OF JOHNSTON MC	5555 PIONEER PARKWAY JOHNSTON, IA 50131

(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 350	Continued From page 9 A progress note dated 11/06/25 noted the change of condition assessment and move to memory care and further noted "continue current plan of care. Service agreement is up to date." (referred to the 10/23/25 created service plan, signed by parties 11/04/25.) A service plan dated 12/07/25 (print date at top of document) failed to address Tenant #C1's independence with toileting, independence with mobility/ambulation with use of a four-wheeled walker, failed to identify the required AM reassurance check per the evaluation, but identified a reassurance check with an effective date of 11/12/25, and identified the check was to be completed nightly at 10:30 p.m., and instructed staff to "please assist (Tenant #C1) into her pjs after the news. Ensure she has her pjs on, dentures brushed and soaking. Face-to-face check on resident status." During an interview with the Executive Director (ED) on 1/12/26 at 3:30 p.m., the ED confirmed the comprehensive evaluation and related Activities of Daily Living (ADL) tasks. When interviewed on 1/15/26, the Director of Health and Wellness confirmed the dates above in comparison with the date of and identified needs per the evaluation and acknowledged the discrepancies. The Program policy entitled "Service plan - AL-IA", dated 6/13/25 included the following procedural step: "A service plan shall be developed for each tenant based on the evaluations conducted in accordance with sub rules 69.22(1) and 69.22(2) and shall be designed to meet the specific needs of the	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0459	A. BUILDING: _____ B. WING _____	C 01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW OF JOHNSTON MC	5555 PIONEER PARKWAY JOHNSTON, IA 50131

(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 350	Continued From page 10 individual tenant." On 1/20/26 at 11:50 a.m. the Executive Director confirmed the above findings.	A 350		
A 410	481-69.26(4)d Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: d. For tenants who are unable to plan their own activities, including tenants with dementia, a list of person-centered planned and spontaneous activities based on the tenant's abilities and personal interests. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure service plans were individualized and included a list of person-centered planned and spontaneous activities based on the tenant's ability and personal interests of preferences for 5 of 5 memory care tenants reviewed (Tenant #C1, Tenant #2 through Tenant #5). Findings follow: Record review from 1/12/26 to 1/20/26 revealed the following memory care tenant service plans failed to have an activity section listed, identify a list of person-centered planned and spontaneous activities based on each tenant's personal interests and preferences: 1) Tenant #C1's service plans dated 10/23/25 and 12/07/25. 2) Tenant #2's service plan dated 4/01/24. 3) Tenant #3's service plan dated 1/07/26. 4) Tenant #4's service plan dated 4/25/25.	A 410		

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
	S0459	A. BUILDING: _____ B. WING _____	C 01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW OF JOHNSTON MC	5555 PIONEER PARKWAY JOHNSTON, IA 50131

(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 410	Continued From page 11 5) Tenant #5's service plan dated 6/20/25. On 1/20/26 at 11:50 a.m. the Executive Director confirmed the above findings.	A 410		

A150 – 48167.2(3) Program Policies and Procedures

1. How the deficiency was corrected for the individual tenant (Tenant #C1):

Tenant #C1's plan of care was reviewed and implemented as developed at the time of the incident. Upon identification of a change in condition, staff initiated appropriate notification and transfer. Due to the tenant's transfer to the hospital for evaluation and treatment, no immediate changes were made to the plan of care. Tenant #C1 was hospitalized and has since been discharged.

2. How the Program identified other tenants who may have been affected:

The Program reviewed current memory care tenant records, including comprehensive evaluations, service plans, service documentation and reassurance check service.

3. What corrective actions were taken for other affected tenants:

As a result of the review, reassurance checks were added to memory care tenants service plans to include every two hour checks, consistent with Program policy.

4. How the Program will prevent recurrence:

The Program reviewed internal procedures for documentation of reassurance checks on service plans every two hours for memory care tenants and ensure alignment between assessments and service plans for memory care tenants and reeducated clinical staff on 4/8/26, 4/9/26, and 4/10/26 on current policies of Direct Care Staffing-AL-IA, Dementia Specific Unit-Safety (IA), and Service Plans-AL-IA.

5. How ongoing compliance will be monitored:

The Director of Health Services will conduct a random review of service plans and reassurance check documentation during next Quality Assurance meeting on April 27, 2026 and again at following Quarterly Quality Assurance meeting for compliance with documentation standards and any identified discrepancies will result in corrective action and reeducation as needed.

Date completed: 4/8/26

A350 – 48169.26(1) Service Plans

1. How the deficiency was corrected for the individual tenant (Tenant #C1):

Tenant #C1's plan of care was reviewed and implemented as developed at the time of the incident. Upon identification of a change in condition, staff initiated appropriate notification and transfer. Due to the tenant's transfer to the hospital for evaluation and treatment, no immediate changes were made to the plan of care. Tenant #C1 was hospitalized and has since been discharged.

2. How the Program identified other tenants who may have been affected:

A review of memory care tenant service plans was completed to compare evaluation findings against documented service plan interventions including ADL status and reassurance checks.

3. What corrective actions were taken for other affected tenants:

Service plans were reviewed and revised if needed, to ensure tenant's identified needs and preferences were met.

4. How the Program will prevent recurrence:

Clinical staff responsible for service planning received reeducation on 4/8/26 regarding the current policies for Service Plans-AL-IA, Dementia Specific Unit-Safety (IA), Direct Care Staffing-AL-IA, and Evaluation of Assisted Living Tenants-IA.

5. How ongoing compliance will be monitored:

The Director of Health Services will conduct a random review of service plans and reassurance check documentation during next Quality Assurance meeting on April 27, 2026 and again at following Quarterly Quality Assurance meeting for compliance with documentation standards and any identified discrepancies will result in corrective action and reeducation as needed.

Date completed: 4/17/26

A410 – 48169.26(4)(d) PersonCentered Activities

1. How the deficiency was corrected for affected tenants:

Tenant #C1's plan of care was reviewed and implemented as developed at the time of the incident. Due to the tenant's transfer to the hospital for evaluation and treatment, no immediate changes were made to the plan of care. Tenant #C1 was hospitalized and has since been discharged.

2. How the Program identified other tenants who may have been affected:

Upon review of the service plans, it was determined not all service plans reflected tenant's abilities, interests, and preferences in regard to activities.

3. What corrective actions were taken for other affected tenants:

The Program reviewed and updated service plans for current memory care tenants to include a section identifying personcentered planned and spontaneous activities based on each tenant's abilities, interests, and preferences in regard to activities.

4. How the Program will prevent recurrence:

New service plans and annual reviews will include each tenant's abilities, interests, and preferences in regard to activities.

5. How ongoing compliance will be monitored:

The Director of Health Services will conduct a random review of service plans for activity related services and documentation during next Quality Assurance meeting on April 27, 2026 and again at following Quarterly Quality Assurance meeting for compliance with documentation standards and any identified discrepancies will result in corrective action and reeducation as needed.

Date completed: 4/17/26