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
	S0286	A. BUILDING: _____ B. WING _____	C 04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRVING POINT	910 7TH STREET SE CEDAR RAPIDS, IA 52401

(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 are defined by the type of population served. Census numbers were provided by the Program at the time of the on-site visit. Tenants without cognitive impairment: 53 Tenants with cognitive impairment: 1 Total census: 54 The following regulatory insufficiencies were identified related to the investigation of Incident #130688-I, Complaint #131767-C, and the recertification visit conducted to determine compliance with certification of an Assisted Living Program:	A 000	see attached POC 6/11/26	
A 232	481-69.22(3) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to complete evaluations as needed following a significant change in condition. This pertained to 1 of 2 discharged tenants reviewed (Tenant C1). Finding follows:	A 232		

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

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A 232	Continued From page 1 A record review on 4/23/26 of Tenant C1's file revealed Patient Communication Notes indicating the following: -On 10/17/25, the staff at the lab reported Tenant C1's urinalysis (UA) showed abnormalities but a culture did not have growth. The UA was negative. -On 10/20/25, Tenant C1's primary care provider (PCP) was notified and a call back was requested regarding the A (negative result) , the tenant's increased confusion and seeing planes that were not there. -On 10/21/25, the PCP's office was called and made aware Tenant C1 had some abnormalities, the culture was negative and there was no urinary tract infection (UTI). Tenant C1 still had hallucinations on and off. He thought he saw a plane outside and his friend was in the crash. He also asked staff about his pet's leash as it was in his hands. He was not wandering and was currently safe. The PCP's office communicated no changes but if he started to wander or was unsafe to send to the emergency department (ED). - On 10/22/25, it was noted Tenant C1 entered into a managed risk agreement on 9/18/25 related to missing medication times and becoming aggressive and hostile toward staff. - On 10/22/25, Tenant C1 was transported to the hospital by ambulance for self-inflicted wounds (note created on 10/23/25). Continued record review revealed	A 232		

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A 232	Continued From page 2 Communication Log entries indicating the following: - On 10/13/25, Tenant C1 was wandering on the third floor and downstairs. He was lost, confused, and required redirection several times. Staff assisted Tenant C1 and his pet with the elevator as he had forgotten how to use it and how to exit the building. -On 10/15/25, a UA was needed. - On 10/16/25, Tenant C1 continued to exhibit unusual behavior, including wandering the halls and staring blankly. -On 10/16/25, the UA was collected and sent out. - On 10/17/25, Tenant C1 was found standing outside the building. When staff asked where he was going, he stated he was waiting for an airplane. Staff encouraged him to come inside, but he subsequently went back outside without his pet. -On 10/17/25, Tenant C1 was confused when walking his pet and asked where the leash was, when it was in his hand. -On 10/20/25, the PCP was updated about increased confusion, seeing things not there and the results of the UA (negative). Tenant C1 was scheduled to see a provider at the memory care clinic in January, if he was unsafe to send him to the ED. -On 10/22/25, Tenant C1 was sent to the hospital for self-inflicted wounds.	A 232		

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A 232	Continued From page 3 -On 10/22/25, Tenant C1 was admitted to psych. Further record review revealed staff statements were gathered by the Program related to the last 48 hours (prior to the self-inflicted wounds) for Tenant C1. Staff reported the following in the statements collected: Tenant C1 was often seen wandering, "clueless" and talked to himself. He was quiet and wandered the hallway. Staff noted he was not taking his pet outside as often. On 10/17/25 was seen outside at 6:50 a.m. in the dark, without his jacket or pet and was waiting for an airplane as the first airplane crashed. Staff noted Tenant C1 appeared to be confused, stayed in his apartment more often and forgot where his apartment was located. Continued record review revealed Tenant C1's had a 90 day evaluation on 9/26/25 and a change of condition evaluation completed on 7/7/25. Evaluations were not completed as needed with significant change with changes noted above with Tenant C1. 2. When interviewed on 4/28/26 at 11:13 a.m. the Clinical Supervisor confirmed the above finding.	A 232		
A 268	481-69.25(1)i Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for	A 268		

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A 268	Continued From page 4 treatment, therapy, and medication; and nurses' notes written by exception; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Record review on 4/23/26 of Tenant C1's file revealed a Patient Communication Note created 10/23/25 indicated on 10/22/25 (note date) Tenant C1 was taken to the hospital by ambulance for self-inflicted wounds. Continued record review revealed Communication Log entries indicated the following: -On 10/22/25, Tenant C1 was sent to the hospital for self-inflicted wounds. -On 10/22/25, Tenant C1 was admitted to psych. Further record review revealed a list of discharged tenants indicated Tenant C1 moved out on 11/30/25. He went to a behavioral unit and then transferred to another facility. Continued record review revealed a nurse's note was not completed related to Tenant C1's discharge from the Program. 2. Record review on 4/27/26 of Tenant C2's file revealed Patient Communication Notes indicated	A 268		

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A 268	Continued From page 5 the following: -On 1/26/26 (late entry for 12/19/25), the Administrator told Tenant C2's legal representative that a higher level of care was needed for Tenant C2. -On 1/26/26, Tenant C2's primary care provider (PCP) was notified Tenant C2 received an involuntary transfer notice and needed to find another placement by 2/22/26. Continued record review revealed a list of discharged tenants indicated Tenant C2's date of discharge was 1/31/26. Further record review revealed a discharge note was not completed related to Tenant C2's discharge from the Program. When interviewed on 4/28/26 at 11:13 a.m. the Clinical Supervisor confirmed a discharge note was not completed for Tenant C2. She confirmed all nurse's notes were provided for the tenants reviewed.	A 268		
A 274	481-69.25(1)o Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and include: o. Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports need not be included in the tenant's medical record);	A 274		

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A 274	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete incident reports. This pertained to 1 of 1 discharged tenant reviewed that had wandering episodes (Tenant C2). Finding follows: Record review on 4/27/26 of Tenant C2's file revealed an Incident Report indicated on 11/28/25 indicated staff from a nearby hospital called to tell Program staff that Tenant C2 was at the hospital and she was confused and disoriented. She did not know the location of her home and was trying to get to the grocery store to buy cat food. Leadership staff were notified and it was decided to have her seen in the emergency department (ED). Continued record review revealed Patient Communication Notes indicated the following: -On 1/26/26 (late entry for 12/19/25), the Administrator told Tenant C2's legal representative that a higher level of care was needed for Tenant C2. -On 1/12/26 it was noted that on 1/11/26 the Clinical Supervisor received a call from second shift staff regarding Tenant C2 had wandered to a nearby hospital and wanted to get cat food. The Clinical Supervisor would notify the Administrator that Tenant C2 had wandered and she was safe. Further record review revealed on 9/23/25 Tenant C2 was staged at a three on the Global Deterioration Scale (GDS), which indicated mild	A 274		

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A 274	Continued From page 7 cognitive decline. They were staged at a four on the GDS on 12/2/25, which indicated moderate cognitive decline. Tenant C2's diagnoses included early onset dementia. Continued record review revealed an incident report was not completed related to Tenant C2's second episode of wandering outside of the building on 1/11/26. When interviewed on 4/28/26 at 11:13 a.m. the Clinical Supervisor confirmed an incident report was not found for Tenant C2 related to the 1/11/26 incident. When interviewed on 4/28/26 at 9:05 a.m. the Administrator confirmed an incident report was not found for Tenant C2 related to 1/11/26 incident.	A 274		
A 280	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with rule 481-69.22(231C) and be designed to meet the specific needs of the individual tenant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans to reflect the specific needs of the tenants. This pertained to 3 of 5 current tenants reviewed (Tenants #1, #2, and #4). Findings follow:	A 280		

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A 280	Continued From page 8 1. Record review on 4/27/26 revealed Tenant #1's file included a managed risk agreement dated 2/24/26. The managed risk agreement indicated Tenant #1 concealed prescribed medications and took medications outside of the times they were administered. Tenant #1 also contacted providers for medication changes without coordination with the nursing staff. She yelled and screamed, which was disruptive to other tenants. She had verbal aggression towards staff that included yelling and calling names. Continued record review revealed Patient Communication Notes indicated the following: -On 2/25/26, a meeting was held with Tenant #1 and her spouse. Tenant #1 entered into a managed risk agreement on 2/24/26. It was asked if a visual check (of the apartment) could be completed to ensure all over the counter (OTC) medications were removed and Tenant #1 was agreeable. The day prior five OTC medications were removed. A bottle of Dulcolax gummies and a bottle of acetaminophen were found and a handful of loose pills were in the bottom of the dresser drawer. She was reminded not to purchase OTC medications without doctor knowledge and to let the care team know as well. -On 2/27/26, during a visit Tenant #1 mentioned she was going to call and ask for her Risperdal to be increased to twice per day. -On 3/6/26, Dulcolax tablets were found in her apartment with five tablets missing. It was noted the medication had been removed two different times.	A 280		

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A 280	Continued From page 9	A 280		

-On 3/12/26, staff reported Tenant #1 requested a clonazepam and she tried to hide the pill for later by putting it under the leg. Staff were instructed to watch her take the medications due to the behavior. Tenant #1 could have her nebulizer, inhaler, nasal spray, eye drops, nystatin swish and swallow and diclofenac gel. Staff assisted her with all other medications and as needed medications.

-On 3/20/26, a meeting (30-day transfer notice) was held with Tenant #1 and her spouse. It was discussed she had a managed risk agreement that was not followed. On two occasions she tried to hide clonazepam. It was discussed they would help her find a place that could better meet her needs.

Further record review revealed Tenant #1's service plan was signed on 7/1/25 and reflected staff assisted with medication management. The service plan reflected Tenant #1 managed the inhalers and nebulizers independently. The service plan did not reflect the issues as identified in the managed risk agreement as indicated above related to medication management and behaviors. It also did not reflect the additional medications Tenant #1 self-administered including eye drops, diclofenac gel, and nystatin swish and swallow.

2. Record review on 4/27/26 of Tenant #2's file revealed frequent emergency department (ED) and hospital visits. A list of tenant hospitalizations/ED visits indicated the following:

-On 2/2/26 Tenant #2 went to the ED for right thigh pain.

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A 280	Continued From page 10 -On 2/18/26 Tenant #2 went to the ED for not feeling well. -On 2/22/26 Tenant #2 went to the ED for epistaxis -On 2/22/26 to 2/23/26 Tenant #2 went to the ED, she could not breathe, her nose was packed and it was painful. -On 2/26/26 to 3/3/26 Tenant #2 went to the ED, she was admitted (inpatient) for hallucinations and kidney injury. -On 3/10/26 Tenant #2 was sent to the ED for weakness, right knee pain. -On 3/14/26 to 3/15/26 Tenant #2 was sent to the ED for swollen feet, ankles. -On 3/20/26 Tenant #2 was sent to the ED for high blood pressure. -On 3/25/26 Tenant #2 was sent to the ED for swollen legs and shortness of breath (SOB). -On 3/30/26 Tenant #2 was sent to the ED for SOB and elevated blood pressure. -On 4/4/26 Tenant #2 was sent to the ED for SOB and elevated blood pressure. -On 4/5/26Tenant #2 was sent to the ED for epistaxis. -On 4/8/26 to 4/13/26 it was noted Tenant #2 was sent to the ED and was admitted (inpatient) for fluid overload, SOB, low hemoglobin, chills, and high blood pressure.	A 280		

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A 280	Continued From page 11 Continued record review of a Patient Communication Note dated 4/6/26 indicated family was asked to buy Tenant #2 neoprene sleeves. When interviewed on 4/28/26 at 11:13 a.m. the Clinical Supervisor indicated Tenant #2 was trying to wear her continuous positive pressure airway (CPAP) machine and she was non-compliant. Staff assisted her in the afternoon with it and she would wear it for an hour and about two and a half hours at night. She should wear it eight to nine hours per night. Tenant #2 was very tired by supper time. She indicated Tenant #2 was borderline needing a higher level of care. Tenant #2 had the compression sleeves for about two weeks. Further record review revealed Tenant #2's service plan signed on 4/13/26 indicated she had a CPAP and it was worn occasionally. The service plan reflected Tenant #2 had a CPAP and staff assisted to put on the mask at night and during the afternoon. The service plan did not reflect Tenant #2's non-compliance with the CPAP, the compression sleeves, or the frequent ED and hospitalization visits including for SOB and elevated blood pressure. 3. Record review on 4/27/26 of Tenant #4's file revealed a tenant hospitalization list indicated the following: -On 2/4/26 Tenant #4 was sent to the ED for chest pain and shortness of breath. -On 2/12/26 to 2/16/26 Tenant #4 was sent to the ED, he was admitted (inpatient) with influenza A	A 280		

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A 280	Continued From page 12 and pneumonia. -On 2/18/26 to 2/23/26 Tenant #4 was sent to the ED and was admitted (inpatient) for pneumonia. -On 4/6/26 to 4/10/26 Tenant #4 was sent to the ED and was admitted (inpatient) for respiratory syncytial virus (RSV) and pneumonia. -On 4/16/26 Tenant #4 was sent to the ED with weakness from a PCP appointment. Continued record review revealed Tenant #4's service plan did not reflect the history of respiratory illnesses and frequent ED and hospital visits. When interviewed on 4/28/26 at 11:13 a.m. the Clinical Supervisor confirmed the above finding.	A 280		
A 282	481-69.26(3) Service Plans 481-69.26(231C) Service plans. 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. The service plan shall be signed by all parties, including the tenant or tenant's legal representative. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update tenants' service plans as needed with significant change. This pertained to 2 of 2 discharged tenants reviewed	A 282		

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A 282	Continued From page 13 (Tenant C1 and Tenant C2). Findings follow: 1. Record review on 4/23/26 of Tenant C1's file revealed Patient Communication Notes indicated the following: -On 10/17/25, the staff at the lab reported Tenant C1's urinalysis (UA) showed abnormalities but a culture did not have growth. The UA was negative. -On 10/20/25, Tenant C1's primary care provider (PCP) was notified and a call back was requested regarding the UA (negative result) and his increased confusion and seeing planes that were not there. -On 10/21/25, the PCP's office was called and made aware Tenant C1 had some abnormalities, the culture was negative and there was no urinary tract infection (UTI). Tenant C1 still had hallucinations on and off. He thought he saw a plane outside and his friend was in the crash. He also asked staff about his pet's leash as it was in his hands. He was not wandering and was currently safe. The PCP's office communicated no changes but if he started to wander or was unsafe to send to the emergency department (ED). -On 10/22/25, Tenant C1 had a managed risk agreement on 9/18/25 related to not being at his apartment at medication times and also related to becoming aggressive and hostile towards staff. -On 10/23/25 (note created) 10/22/25 (note date), Tenant C1 was taken to the hospital by ambulance for self-inflicted wounds.	A 282		

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IRVING POINT	910 7TH STREET SE CEDAR RAPIDS, IA 52401

(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 282	Continued From page 14 Continued record review revealed Communication Log entries indicated the following: -On 10/13/25, Tenant C1 was wandering on the third floor and downstairs. He was lost, confused and was redirected a few times. Staff took Tenant C1 and his pet down the elevator as he forgot how to use it and how to get outside. -On 10/15/25, a UA was needed. -On 10/16/25, Tenant C1 continued strange behavior, wandered the halls and was just staring. -On 10/16/25, the UA was collected and sent out. -On 10/17/25, Tenant C1 was standing outside of the building when staff arrived. When asked where he was going he said he was waiting for the airplane. Staff told him to come inside and clear his mind and take his pet for a walk. Tenant C1 agreed and went back outside without his pet. -On 10/17/25, Tenant C1 was confused when walking his pet and asked where the leash was, when it was in his hand. -On 10/20/25, the PCP was updated about increased confusion, seeing things not there and the results of the UA (negative). Tenant C1 was scheduled to see a provider at the memory care clinic in January, if he was unsafe to send him to the ED. -On 10/22/25, Tenant C1 was sent to the hospital for self-inflicted wounds.	A 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0286	A. BUILDING: _____ B. WING _____	C 04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRVING POINT	910 7TH STREET SE CEDAR RAPIDS, IA 52401

(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 282	Continued From page 15 -On 10/22/25, Tenant C1 was admitted to psych. Further record review revealed staff statements were gathered by the Program related to the last 48 hours (prior to the self-inflicted wounds) for Tenant C1. Staff reported the following in the statements collected: Tenant C1 was often seen wandering, "clueless" and talked to himself. He was quiet and wandered the hallway. Staff noted he was not taking his pet outside as often. On 10/17/25 was seen outside at 6:50 a.m. in the dark, without his jacket or pet and was waiting for an airplane as the first airplane crashed. Staff noted Tenant C1 appeared to be confused, stayed in his apartment more often and forgot where his apartment was located. Continued record review revealed Tenant C1's service plan was signed on 7/7/25. The service plan was not updated as needed with significant change and did not reflect the behaviors and changes as noted above. 2. Record review on 4/27/26 of Tenant C2's file revealed an Incident Report indicated on 11/28/25 staff from a nearby hospital called and told Program staff that Tenant C2 was at the hospital, confused and disoriented. She did not know the location of her home and was trying to get to the grocery store to buy cat food. Leadership staff were notified and it was decided to have her seen in the ED. Continued record review revealed Patient Communication Notes indicated the following: -On 1/26/26 (late entry for 12/19/25), the Administrator told Tenant C2's legal representative that a higher level of care was	A 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0286	A. BUILDING: _____ B. WING _____	C 04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRVING POINT	910 7TH STREET SE CEDAR RAPIDS, IA 52401

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A 282	Continued From page 16 needed for Tenant C2. -On 1/12/26 (note created) 1/11/26 (note date), the Clinical Supervisor received a call from second shift regarding Tenant C2 had wandered to a nearby hospital and wanted to get cat food. The Clinical Supervisor would notify the Administrator that Tenant C2 had wandered and she was safe. Further record review revealed on 9/23/25 Tenant C2 was staged at a three on the Global Deterioration Scale (GDS), which indicated mild cognitive decline. She was staged at a four on the GDS on 12/2/25, which indicated moderate cognitive decline. Tenant C2's diagnoses included early onset dementia. Continued record review revealed and evaluation was completed with significant change dated 12/2/25. It reflected last Friday Tenant C2 walked to the hospital looking for cat food and was trying to get to a grocery store. She could not remember how to get back home. Tenant C2 was sent to the ED for evaluation and a UA. It was negative for a UTI. She was sent home and put on two hour checks while awake and four hour checks when asleep. Further record review revealed Tenant C2's service plan was signed on 1/31/25. The service plan was not updated related to the wandering episodes, interventions for safety and visual checks. When interviewed on 4/28/26 at 11:13 a.m. the Clinical Supervisor confirmed the above finding.	A 282		

Irving POINT
AFFORDABLE ASSISTED LIVING

May 28, 2026

Department of Inspections and Appeals
Attn: Frieda Paul, Program Coordinator
6200 Park Avenue, Suite 100
Des Moines, Iowa 50321-1270

Dear Ms. Paul:

On behalf of Irving Point in Cedar Rapids, I respectfully submit our Plan of Correction for your approval. This response is specific to the report completed on April 28, 2026. 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 conclusion set forth in the statement of insufficiencies. The Plan of Correction is executed solely because it is required by the provisions of Iowa Law.

Evaluation of Tenant

1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.
    - Tenant C1 no longer resides at Irving Point. All tenants will have evaluations completed as required by regulation when there is a significant change in condition.

2. Measures taken to ensure the problem does not recur.
    - *The RN and nurse designee(s) will be re-educated on regulatory requirements for evaluation of tenants.*

3. How the Program plans to monitor performance to ensure compliance.
    - *The Administrator or Designee will review tenant files at least annually to confirm compliance.*

4. The date by which the regulatory insufficiency will be corrected.
    - *This plan of correction will be completed on or before June 11, 2026.*

Tenant Documents

1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.
    - Tenants C1 and C2 no longer reside at Irving Point.
    - All tenants who discharge from Irving Point will have a discharge summary documented in progress notes.
    - Incident reports will be completed as required by regulation and Program policy.

910 7th Street S.E. ▪ Cedar Rapids, Iowa 52401
(319) 294-5007 ▪ (319) 362-3731 fax

2. Measures taken to ensure the problem does not recur.
    - *The RN and nurse designee(s) will be re-educated on documentation in progress notes, specifically when tenant discharges from the Program.*
    - *All staff will be re-educated on regulatory requirement and Program policy for completion of incident reports.*

3. How the Program plans to monitor performance to ensure compliance.
    - *The Administrator or Designee will review tenant files at least annually to confirm compliance.*

4. The date by which the regulatory insufficiency will be corrected.
    - *This plan of correction will be completed on or before June 11, 2026.*

Service Plan

1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.
    - All tenants will have a service plan that identify tenant needs and preferences for assistance.
    - All tenants will have a service plan updated with a significant change in condition, and as required by regulation.

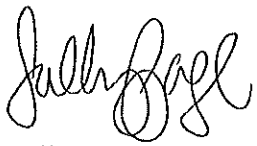
2. Measures taken to ensure the problem does not recur.
    - *The RN and nurse designee(s) will be re-educated on regulatory requirement for service plan.*

3. How the Program plans to monitor performance to ensure compliance.
    - *The Administrator or Designee will review tenant files at least annually to confirm compliance.*

4. The date by which the regulatory insufficiency will be corrected.
    - *This plan of correction will be completed on or before June 11, 2026.*

Contact me at 319-294-5007 with any questions. Thank you.

Sincerely,



Sally Page
Administrator