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 08/27/2026

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. The census numbers were provided by the Program at the time of the on-site. Tenants without cognitive impairment: 54 Tenants with cognitive impairment: 0 Total census: 54 Complaint #132192-C was investigated and the complaint was substantiated; however, no regulatory insufficiency was cited. The following regulatory insufficiencies were identified related to the investigation of Complaints #132193-C, #132326-C and #132336-C:	A 000	See attached POC 10/28/26	
A 121	481-67.3(1) Tenant Rights 481-67.3(231B,231C,231D) Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to treat a tenant with respect, dignity and consideration. This pertained to 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: Record review on 8/25/26 of a document provided by the Program indicated on 6/5/26 Tenant C1's family member came into the Administrator's office, was upset and asked if a	A 121		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

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A 121	Continued From page 1	A 121		

video could be viewed by the Administrator. The video showed a staff enter the apartment to provide scheduled services. Tenant C1 received a telephone call from the family member regarding him not feeling well. After the phone call and "interaction" occurred between Tenant C1 and the staff. In the video Tenant C1 made comments to the staff and staff responded that she was aware and had been providing services daily. Tenant C1 continued the conversation and the staff said that she "just wanted to get this sh** over with." Tenant C1 asked the staff to leave and she said she would leave and said that she and other staff were tired of his behavior. The staff said she had been working with her supervisor on a different issue with Tenant C1, when they had repeatedly questioned staff about her whereabouts. Staff contacted her to come in and provide services. The staff said multiple times that she was frustrated with Tenant C1. She offered to find another staff to complete his services. Staff then left the apartment. Tenant C1 contacted his family member right after and told the family member what had occurred. The family member said that Tenant C1 was "extremely ill." Tenant C1's family member "characterized the staff interactions as verbal assault" and stated the family member intended to contact law enforcement." The family member was told that the family member could contact any agency. The family member was told the Program would be investigating immediately. Law enforcement came to the property but did not enter the building to the Administrator's knowledge. The staff involved was interviewed and received coaching related to appropriate communication and interactions with tenants. It also included maintaining professionalism during interactions that were difficult.

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A 121	Continued From page 2 Record review Record review from 8/24/26 to 8/27/26 of Tenant C1's file revealed he was admitted on 7/8/24 and discharged on 8/8/26. The service plan reflected Tenant C1 required had daily bowel and urine incontinence and required assistance with perineal cares. He utilized urinals and staff emptied the urinals in the morning. Continued record review revealed an Incident Documentation-Employee Coaching documented indicated the date of the incident was 6/5/26. On 6/5/26 Tenant C1's family member brought a video to the Administrator related to an interaction between the tenant and Staff F. The video was reviewed and showed Staff F used an "inappropriate word while expressing frustration with the situation involving the tenant." Staff F explained Tenant C1 had repeatedly contacted the staff phone when she attempted to complete other tasks and on occasions had contacted staff again before she was able to finish the task was attempting. Staff F said Tenant C1's repeated interruptions had become frustrating. Staff F was reminded that was staff were to be professional and respectful with communication when interacting with tenants. Staff F was also reminded to be mindful of her language and to get help from another staff or the Administrator when she felt a situation was frustrating. Further record review revealed an Employee Counseling Interview indicated on 6/5/26 Staff F had inappropriate communication with Tenant C1. "Employee spoke to tenant in a rude and upprofessional (sic) manner." The staff was counseled that all tenants must be treated with respect and professionalism at all times. The form was signed by Staff F and it was dated 6/5/26. It was also signed by the Supervisor and	A 121		

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dated 6/5/26.

On 8/25/26 at 5:13 p.m. Tenant C1 was interviewed. He said he asked staff to help get him cleaned up. Staff was apparently agitated, came into his apartment and blew up and started yelling at him. He said there was a video and the staff could be heard.

When interviewed on 8/25/26 at approximately 3:25 p.m. Staff F said Tenant C1 had continually called on the phone that day, three times as she was providing another care. She was pulled from it to attend to him. Staff F said she was frustrated with him. Tenants were not supposed to call repeatedly. She went to his apartment and said why she was frustrated and she had been pulled from a care. Tenant C1 had said something that had frustrated her before. She said she was ready to get her "sh**" done and over with because she was frustrated. Tenant C1 asked her to leave. She offered to have someone else come help him, and left. Tenant C1 did not accept the offer, and declined to have his brief changed. She continued on with her day and was pulled out of a care by the Supervisor. Tenant C1 had called his family member and said Staff F was verbally abusive. Police were called and nothing further occurred. Tenant C1 had called that day for brief change and he required physical assistance with a brief change in bed. Staff F talked to management about it and she did not have further issues. She had a coaching review and she signed that form today. She had verbal coaching before. Staff F said she was not threatening or name calling to Tenant C1. After that she did provide cares to him, he made taunting remarks to her at meals.

When interviewed on 8/26/26 at 2:58 p.m. the

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Supervisor said Staff F was very upset and said she had used profanity but not at Tenant C1. Staff F said "she was not going to do this sh** anymore" but it was not directed at him. She had a coaching write up on that related to respect. Tenant C1 had been badgering her, she got upset and used profanity. She was re-educated to remove herself, be kind and courteous, and respectful. She was also told to remove herself and not escalate. Staff F was very receptive and there had been no further incidents.
Re-education was completed at the time and form was completed on either 6/5/26 or 6/6/26. Tenant C1 did not want Staff F to come in anymore and he wanted the care so early in the morning. An aide from the community came in Mondays and the other days it was impossible (regarding scheduling and requested timing of cares).

When interviewed on 8/26/236 at 4:55 p.m. the Administrator said Tenant C1's family member came to her office and said there was an incident that morning and had a video. The video was played and the family member said the police were going to be called as the family member felt Tenant C1 was abused. The video showed Staff F said something (not exact verbiage) that she was tired of his behavior and she wanted to get "sh** done." Tenant C1 asked her to leave and she did. She offered to get someone else for his cares as she was changing him after a bowel movement. Tenant C1's response could not be heard but he was very "theatrical" on the phone speaking with family member. Staff F was pulled in and she talked to her and the Supervisor had visited with her beforehand. The police arrived but never came into the building. Staff F said he had kept calling her that morning regarding Staff F's frustration. She was told to walk away and

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A 121	Continued From page 5 come and get the Supervisor or the Administrator and not to match in terms of being disrespectfulness. Staff F was remorseful and there were no further issues. For awhile they did not interact.	A 121		
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 interview and record review the Program failed to provide services, care and treatment that were adequate and appropriate. That pertained to 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Record review from 8/24/26 to 8/27/26 of Tenant C1's file revealed he was admitted on 7/8/24 and discharged on 8/8/26, involuntarily. The service plan indicated Tenant C1 needed to to self-isolate in apartment due to bed bugs per pest control recommendations. It also indicated Tenant C1 had told other tenants he was banned from the dining room per the Administrator versus telling them he had bed bugs. A timeline provided by the Administrator indicated the following: -On 4/9/26 it was noted a bed bug was found in Tenant C1's apartment. Pest control was onsite that afternoon and confirmed "bed bug	A 122		

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infestation."

-On 4/13/26 it was noted pest control completed a treatment. The Program approved the extra charge to get treated to allow the tenant to return to activities as soon as possible.

-On 4/17/26 it was noted Tenant C1 attended a coffee group with multiple tenants in the dining room.

-On 5/1/26 it was noted Tenant C1 played cards with other tenants and was observed in one of the staff's office.

-On 5/6/26 it was noted one adult bed bug was found. The area was spot treated with Tenant C1's permission.

-On 5/6/26 it was noted pest control recommendations were provided to Tenant C1's family member.

-On 5/7/26 it was noted he was seen stopping a staff in the hallway to discuss services and wanting to change times.

-On 5/7/26 it was noted he invited other tenants to have dinner with him at a local restaurant.

-On 5/13/26 it was noted pest control completed a reinspection and Tenant C1 was cleared to resume normal activities.

-On 5/19/26 it was noted staff found a bed bug on his bed.

-On 5/21/26 it was noted pest control found live bugs and told Tenant C1 to limit unnecessary interactions and socialization during active

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treatment. It was discussed with Tenant C1's family member that Tenant C1 must stay in his apartment as much as possible and the family member discussed with him. Later that day Tenant C1 was in the hallway and told the Administrator he was going to follow the instructions from pest control.

-On 5/21/26 it was noted Tenant C1's family member said Tenant C1 went to urgent care due to concerns related to the negative effects related to the chemicals used in the treatment and steroids were prescribed. It was offered to provide the chemicals used to his doctor.

-On 5/21/26 an email was sent to Tenant C1's family member regarding the recommendations from pest control.

-On 5/25/26 it was noted pest control came out and completed a treatment and spoke with Tenant C1 and the family member about the expectation and process.

-On 5/27/26 it was noted Tenant C1 told staff the Administrator was trying to poison him.

-On 5/27/26 it was noted Tenant C1 was seen by a provider and the after visit summary indicated it was for an upper respiratory infection, bedbug bite and pesticide exposure.

-On 5/28/26 it was noted Tenant C1 was seen in the hall with another tenant and they had a conversation and were in contact, which included the other tenant rubbing Tenant C1's back.

-On 6/2/26 a 30-day notice of termination of the month-to-month holdover tenancy was posted on Tenant C1's door.

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A 122	Continued From page 8 -On 6/4/26 it was noted the apartment was inspected and he was released back to normal activities. All electrical chairs were steamed to ensure no further activity. -On 6/18/26 it was noted an involuntary transfer notice was posted to Tenant C1's door. -On 6/18/26 it was noted an email was received from Tenant C1, which appealed the involuntary transfer notice. -On 6/23/26 it was noted a hearing was held with the ombudsman, case manager, Supervisor and Administrator in person and Tenant C1's family attended by phone. 2. Continued record review of Tenant C1's file revealed he signed the occupancy agreement on 7/10/24. He had signed a Pest Control Lease Addendum which indicated included following any other directions given by the pest eradication professionals. Tenant C1 also signed the Supplemental Rules and Regulations addendum, which included tenants, family or guests would not engage in the following directed at other tenants, other family members or guests, the landlord or its management agents or staff, property vendors or inspectors, property lenders or owners: yelling at, using profanity at, berating, demeaning, making false claims, slander, defaming, or conspiring against. Further record review revealed the 30-Day Notice of Termination of Month-To-Month Holdover Tenancy issued to Tenant C1 was dated 6/2/26. It indicated Tenant C1's lease expired on 6/30/25 and he became a month-to-month holdover tenant. The landlord elected to terminate the	A 122		

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month-to-month holdover tenancy. The lease would terminate on 7/31/26. The conduct to support termination indicated:

-The apartment was "currently infested with bedbugs." It further noted, on "numerous recent occasions, you failed to follow the directions given to you by the undersigned landlord's pest eradication professionals (including, without limitation, socializing with other tenants in common areas of the Irving Point facility, which increases the risk that the infestation will spread), in violation of the Pest Control Lease Addendum attached to you lease agreement."

-On or about 5/27/26 Tenant C1 "wrongfully alleged" to a staff member that the Administrator was trying to poison him. That was in violation of the Supplemental Rules and Regulations attached to the lease agreement.

Continued record review of Tenant C1's file revealed a letter dated 6/18/26 an involuntary transfer notice. The letter indicated the involuntary transfer included repeated violations of the Pest Control Lease Addendum and Supplemental Rules and Regulations. It indicated the apartment was currently infested with bedbugs. On numerous occasions Tenant C1 failed to follow the directions given to by the pest eradication professionals. It was in violation of the Pest Control Leave Addendum. It also noted Tenant C1 made statements to staff that administration attempted to poison him, which was in violation of the paragraph 1 (d) of the Supplemental Rules and Regulations attached to the lease. Arrangements needed to be made no later than 8/1/26. If he disagreed with the transfer notice he could appeal via the internal appeal process. Any written materials in support of his

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argument needed to be submitted within 24 hours of the receipt of the letter. An appeal was sent from Tenant C1 to the Administrator, his case manager and the long-term care ombudsman on 6/18/26. A letter dated 6/25/26 to Tenant C1 from the Administrator indicated a hearing was held on 6/23/26 and following the hearing it was determined to uphold the original decision to non-renewal of the lease.

Further record review of Tenant C1's file revealed a Notice To Quit was dated 8/5/26. It indicated that Tenant C1 vacate the apartment within three days from the date of the service on the notice.

3. Record review on 8/26/26 of a timeline provided from the Pest Control Company dated 8/25/26 indicated the following:

-On 4/9/26 a bed bug inspection was completed for Tenant C1's unit. Four to six bed bugs were found on the main electric chair. A spot treatment was completed at the time of the inspection. Tenant C1 permitted to the treatment. A prep list for the full bed bug treatment was also gone over.

-On 4/13/26 it was noted at the time of service no live bed bugs were found. There was one dead one on the floor. All areas of the unit were treated. Tenant C1 was told multiple times that it was recommended to "limit yourself from going anywhere including going down halls and friend's rooms. Tenant was recommended to remain as isolated as possible (leave unit minimally) to control the spread of bugs to any other units as they were easily spread." Tenant C1 was told to mindful of other people in the building and the places he went. Pest control told the Administrator, if possible to keep him from going anywhere in the building until it was handled.

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Tenant C1's family member was also told the restrictions. The family member was told to keep him out of other people's apartments so they were not getting exposed but it wasn't that he could not go places outside of the building.

-On 4/27/26 it was noted multiple dead bugs and old eggs were seen on electric chair seats. Everything was treated again and there were be a final inspection in a week or so. Tenant C1 was spoken to before the treatment and to let him know to let things dry for at least two hours or more.

-On 5/6/26 an email was sent to the Administrator from the Pest Control Company and it indicated it was still the recommendation to restrict going into other tenant apartments and other common gathering areas until he was cleared. If he wanted to leave the facility altogether for the day he could as he wanted. The recommendation was to stay in the unit as much as possible to contain and stop the spread of bed bugs to others. An inspection was scheduled for 5/13/26 if there were no more live bugs, he would be cleared and restrictions would be lifted.

-On 5/13/26 it was noticed during the pest control inspection, one bed bug was found in bag with pillows. A spot treatment was completed on the items in the bag. The tenant was advised he was cleared and Tenant C1's family member was contacted and explained if there were any others to let them know.

-On 5/25/26 it was noted no live bed bugs were seen. Tenant C1's apartment was ready to treat. It was noted Tenant C1 and family member were spoken to about expectations and process.

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-On 6/4/26 it was noted there were no signs of bed bugs on monitor boards or visually. The electric wheelchairs were steamed to ensure there was no activity. The unit was cleared and he could go back to normal activities.

Continued record review Pest Control Company records indicated invoices were provided. One invoice dated 5/13/26 had technician comments that included one adult bed bug was found in the electrical chair and multiple dead ones were found. With tenant's permission the original chair that had issue was spot cleaned. It indicated "Let tenant know to still avoid going every where while this issue still exits."

4. When interviewed on 8/25/26 at 5:13 p.m. Tenant C1 said a bed bug problem was discovered and he was told basically not to leave the apartment. Lasted for a week. It came from the Administrator and pest control verbally. He could not leave his apartment, could not go to common areas, including the dining room. They ended up coming back and found some (bed bugs) and applied an application. He started to feel ill. The wording was changed, he was restricted to his room but could go outside. He went straight out the front door. In email communication to his family member, it indicated he could not talk but he never was. He did not receive that email. Outside it was like COVID-19, six feet away from others. Once inside he went to his apartment. Tenant C1 said he went to urgent care and was not in great shape. He had upper respiratory infection and they said it was probably due to pest control. He asked to be relocated and was not relocated. The treatment was applied all over his wheelchairs, carpet and tile. In June he received a notice posted on his door that he was evicted. The notice said his

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A 122	Continued From page 13	A 122		

apartment was infested with bed bugs but he had been cleared. He appealed but the person making the accusations was the person who granted the appeal. It was messed up to start.

When interviewed on 8/24/26 at 5:54 p.m. Tenant C1's family member said on 4/9/26 a bed bug was found in Tenant C1's apartment. Pest control came out, a prep sheet was provided and pest control spoke with Tenant C1. Written communication went to Tenant C1's family member after that and not Tenant C1. The initial inspection was 4/9/26 and on 4/13/26 restrictions were in place. After two weeks, there was re-test and there was a live bed bug sealed in the apartment. Pesticide was sprayed and it was not good for lungs and he got sick. He was cleared that day and then they found a bed bug under mattress crawling. There was a treatment. Tenant C1's family member asked the Administrator verbally if Tenant C1 could relocate and it was denied. She said restrictions were lifted on 5/13/26 and put back into place on 5/21/26. The emails went to Tenant C1's family member and not to Tenant C1.

When interviewed on 8/27/26 at 12:16 p.m. the Administrator said on 4/9/26 staff found a bed bug and the picture was sent to pest control. Pest control came out and did an inspection. On 4/13/26 a treatment was completed. On that day either the Administrator or the Supervisor talked to Tenant C1. Pest control was asked if he could leave and go off property and pest control said to push back as far as having to do those things if you want to keep others safe and to isolate as much as possible. On 4/13/26 pest control completed a treatment and did not find much. Pest control told Tenant C1 to isolate. She spoke with Tenant C1's family member and she was

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almost positive the Supervisor spoke with Tenant C1 about cares. After that conversations were had with him and he continued to come out to activities and to dining.

On 5/6/26 another bed bug was found the treatment was completed with Tenant C1's permission. Tenant C1's family member was emailed on 5/6/26. It was always the preference to have Tenant C1's family in the loop if there was any conflict or a sit down. Tenant C1 started telling everyone the Administrator banned him from the dining room. He invited other tenants out to a restaurant with him. On 5/13/26 the inspection was completed and he was cleared. When he went to the doctor the Administrator offered to get the chemical list to the provider and it was declined.

On 5/19/26 bed bugs were found. Restrictions were lifted from 5/13/26 to 5/19/26. He was cleared on 6/4/26. The restrictions were to self-isolate as much as possible, if he went outside, don't stop to talk and talk off property. Meals were delivered and staff used precautions with visits. The restrictions started on 4/9/26 to 5/13/26 and 5/19/26 to 6/4/26. On 5/21/26 the Administrator visited with Tenant C1's family member about Tenant C1 saying the Administrator had banned him from the dining room. The meeting did not go well and the Administrator decided to bring her supervisor into it. The Administrator had told Tenant C1's family member about the restrictions and then followed up with an email. Tenant C1's member was supposed to tell him the information. After that he came off the elevator and told the Administrator he had talked to Tenant C1's family member and he would follow all restrictions. He was told that the conversation was a phone

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conversation (versus meeting in person to discuss it). He continued to interact with other tenants. Including him sitting outside talking to another tenant about making a call they had talked about. He was on property (outside). On 5/30/26 or 5/31/26 he was in the dining room and came through the serving area for less a minute. She said he was not to be in the common areas. He was given the non-renewal on 6/2/26 and was cleared (bed bugs) on 6/4/26. After the non-renewal he was observed in the parking talking to tenants. He was given an involuntary transfer on 6/18/26. She did not receive a request to relocate him from Tenant C1 or Tenant C1's family member.

She said regarding documentation for the preference of communication to the family member, she did not think it was not documented but said possibly on an early service plan. She said pest control had verbal discussions with Tenant C1. Off property was communicated to him by either the Administrator or the Supervisor. She said there was a lot of communication, she did not have his email address. Regarding anything in writing regarding the restrictions she said they would not write that.

When interviewed on 8/27/26 at 1:49 p.m. the Supervisor said staff still completed services for Tenant C1 related to the bed bug issue. Staff dressed in gowns and booties. Tenant C1's family member did his laundry. She said she never provided Tenant C1 with information regarding restrictions. She said that was from pest control and the Administrator.

When interviewed on 8/26/26 at 4:28 p.m. the Owner/Technician with the Pest Control Company said there were issues with bed bugs on the

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wheelchair originally. Prep sheets were given and instructions were repeated. He said they were instructed multiple times on what he was doing and safety issues. It was preferred to be out of the apartment two to four hours after treatment. If came back and it was wet to leave for an hour. There were should be no respiratory issues once dried. Not a step was missed. Told him and the family member multiple times. He said he told them on every treatment present to protect others not to go everywhere in the building. Don't go to the neighbors, stay secluded. Be smart about where he went. He everything was clearly spoken to them.

5. Record review on 8/25/26 to 8/27/26 of email correspondence from the Administrator to Tenant C1's family member were provided dated 5/6/26 and 5/21/26. An email was sent to Tenant C1's family member on 5/6/26 that indicated a live bed bug was found on Tenant C1's chair and it was treated immediately onsite. Pest Control recommended again that during the active treatment period that he limit unnecessary interactions and stay primarily in his apartment until they felt it was safe to resume normal activities. It had been the consistent recommendation throughout the course of treatment. Tenant C1 had been participating in social activities around the building and it was important to follow the guidelines to ensure the treatment was successful. It was noted for the family member's support to encourage Tenant C1 to follow the recommendations.

Tenant C1's family member responded on 5/6/26 and said they were more than happy to comply with any recommendations from pest control. There was some confusion as pest control told the family member he was okay to resume social

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activities but still to limit entering apartments so they thought it was okay to play cards and have meals in the dining room. It was noted the family member would advise him until further notice he could not participate in such activities but a timeline of when he could be cleared as requested. It was requested to set expectations with Tenant C1. The family member noted for the last two weeks he was quarantined to his room and it took a toll on his mental health.

On 5/6/26 the Administrator sent the response from Pest Control to Tenant C1's family member which indicated it was still the recommendation to restrict going to other tenant apartments and other common gathering areas until cleared. It was recommended he stay in the unit as much as possible. If he wanted to leave the facility for the day he could do as he wanted. Another inspection would occur on 5/13/26 and if no more live insects were found he would be cleared and restrictions would be lifted. Until then it was still recommended to use caution.

An email dated 5/21/26 sent to Tenant C1's family member from the Administrator indicated following the conversation today the Administrator wanted to provide additional clarification regarding recommendations in place from pest control. There were active bed bugs identified in the inspection on 5/21/26 and pest control recommended he limit unnecessary interactions with other tenants until it was determined it was appropriate to resume normal activities. It was intended to apply both within the building and during off-site social activities that involved other tenants to minimize the risk of further spread during active treatment. Examples included avoiding gathering in common spaces, attending social activities, dining with groups of tenants,

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A 122	Continued From page 18 arranging outings with other tenants until pest control indicated restrictions were no longer necessary. Pest control also provided additional prep instructions. In summary, Tenant C1 signed his own documents that were provided the Program and legal representative paperwork was not on file at the Program. Tenant C1 had signed a Release of Information document, which included Tenant C1's family member. Although there were discussions from the pest control company with Tenant C1 and Tenant C1's family and emails between the Administrator and Tenant C1's family member, there was no documentation provided that indicated Tenant C1 received written expectations from the Program related to the restrictions recommended by pest control. There was no documentation provided by the Program to Tenant C1 that explained the restrictions, the timeline for restrictions and when they were lifted and included information related to on-property and off-property expectations. Tenant C1 was issued a non-renewal of a holdover lease on 6/2/26, which indicated he had a bed bug infestation and failed to comply with rules recommended by pest control, which was a requirement in the Pest Control Addendum. On 6/4/26 (two days after the notice) his apartment was cleared of bed bugs and the restrictions were lifted. Additionally, one of the criteria he was cited for non-renewal pertained to pest control recommendations not followed; however, these restrictions were not clearly documented and provided to Tenant C1 by the Program.	A 122		
A 152	481-67.5(2)e(3) Medications 481-67.5(231B,231C,231D) Medications.	A 152		

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A 152	Continued From page 19 67.5(2)?Each program shall follow its own written medication policy, including the following: e. When medications are administered traditionally by the program: (3) Medications and treatments will be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or PA. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to administer medications as ordered. This pertained to 1 of 1 tenant reviewed (Tenant #3) and 1 of 3 tenants observed on the medication pass (Tenant #5). Findings follow: Record review on 8/25/26 to 8/27/26 of Tenant #3's file revealed an order for Fasenra injection 30 milligram (mg)/milliliters (ml), 30 mg every 8 weeks (nurse administered). The May 2026 medication administration record (MAR) reflected a dose was to be given on 5/21/26; however, it was not documented on the MAR. The July MAR reflected a dose was to be give on 7/16/26; however, it was not documented on the MAR. The MAR reflected a handwritten notation it was last given on 7/17/26 and would be due on 9/11/26. Continued record review revealed a Patient Communication Note dated 7/17/26 pharmacy was called regarding Tenant #3's Fasenra injection as it was ordered the day prior. Pharmacy staff said that it had just come in and	A 152		

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someone would deliver it to them. A Patient Communication Note dated 7/17/26 reflected the Clinical Supervisor administered her injection that came in. The area was cleaned and injection was given without issue.

Further record review of Tenant #3's file revealed the May 2026 MAR also reflected an order or Ozempic injection 4 mg/3 ml, inject 1 mg into skin once weekly (a.m.). It was to be given on 5/7/26, 5/14/26, 5/21/26 and 5/28/26. It was not documented as administered for any of the doses. The MAR reflected "Self."

The June 2026 MARs reflected Ozempic doses were to be given on 6/2/26, 6/9/26, 6/16/26, 6/23/26 and 6/30/26. On 6/2/26 it was documented as refused. The other remaining doses in June were not documented as administered.

The July 2026 MARs reflected Ozempic doses were to be administered on 7/7/26, 7/14/26, 7/21/26 and 7/28/26. It was charted as refused on 7/14/26. None of the other doses in July were documented as administered. The August 2026 MARs reflected Ozempic doses were to be given on 8/6/26, 8/11/26, 8/18/26 and 8/25/26. It was not documented as administered for any of the doses.

When interviewed on 8/27/26 at 2:07 p.m. the Clinical Supervisor said regarding Tenant #3's Ozempic, staff put on the needle, dialed it up, Tenant #3 injected and handed it back to staff. She confirmed staff should be signing off. She had no concerns that Tenant #3 was not receiving it. Regarding the Fasenra, she said typically the nurse completed (administered it) with the nurse visit. She did not know the nurse should sign it

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out on the MAR as it was typically given during a nurse visit.

When observed on 8/26/26 at approximately 11:05 a.m. Staff B administered medications to three tenants including Tenant #5. Staff B charted a medication Diclofenac Gel 1%, apply to affected areas four times daily as not available to administer during the medication pass observed.

Record review on 8/27/26 of Tenant #5's August 2026 MAR reflected there were no doses documented as administered in the month of August. There was one omission on 8/3/26 at bedtime, the remaining entries were staffs' initials and were circled. The back of the MAR reflected the medication was not available to administer. The MAR had a notation that it was an over the counter (OTC) medication.

Continued record review on 8/27/26 of Tenant #5's August 2026 MAR reflected an order for calcium/vitamin D3 600-400, take ½ tablet by mouth twice daily (a.m. and p.m.). There was one omission on 8/3/26 at p.m., the remaining entries were staffs' initials and were circled. The back of the MAR reflected it was not available to administer.

Further record review on 8/27/26 of Tenant #5's August 2026 MAR reflected an order for Senexon-S tablet 8.6-50 mg, take one tablet by mouth twice daily. There was one omission on 8/3/26 at p.m., the remaining entries were staffs' initials and were circled. The back of the MAR reflected the medication was not available to administer. The MAR had a notation that it was an OTC medication.

When interviewed on 8/27/26 at 2:07 p.m. the

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A 152	Continued From page 22 Clinical Supervisor said Tenant #5 had been sleeping and refusing her medications. There were no issues with medication deliver from pharmacy. OTC medications she purchased herself.	A 152		
A 198	481-67.9(4)d Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall include the following: d. Direct care staff will receive training regarding service plan tasks in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide nurse delegated training on all service plan tasks. This pertained to 5 of 5 staff reviewed that currently passed medications (Staff A, B, C, D, and E). Findings follow: When interviewed on 8/25/26 at 3:47 p.m. and 4:19 p.m. and 8/27/26 at 2:07 p.m. the Clinical Supervisor said if staff called and said they did not have the medication on the medication administration record (MAR) she would have them scan the MAR and would look at the script. She would have staff take a picture of the order, repeat it back to her and she told them what to put on the MAR. She checked it to ensure it was	A 198		

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right (when back in the building). Any medication passer could do it. She always put orders on the MAR if she was in the building but all medication passers could do it if she was not there. It was dated on the MAR, if it was discontinued it was highlighted in yellow. Staff asked questions and there was good communication of orders. Within delegation she always did it but now there was new delegation to use and it would be used going forward. She said there were no issues with transcription of orders. She said it was covered in the medication training but a new delegation form was created today (8/25/26). She said it would be covered by the end of the week.

Record review on 8/25/26 revealed a document titled Delegations: How to write new med on the MAR. It included instructions on how to add a new medication, change a medication dose or time.

Continued record review revealed nurse delegations were requested regarding transcription of orders were requested for staff including for Staff A, B, C, D, and E. None were completed when the delegations were initially requested. Delegations were later provided on 8/27/26 for Staff A (dated 8/27/26), Staff B (dated 8/27/26) and Staff E dated (8/25/26). A delegation form was also provided for the Supervisor dated 8/25/26.

When interviewed on 8/27/26 at 2:04 p.m. the Clinical Supervisor said it was always discussed (within delegations) but she was not realize it needed to be written down.

Irving POINT
AFFORDABLE ASSISTED LIVING

October 9, 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.

Tenant Rights

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 staff will be re-educated on tenant approach and customer service.*
    - *All communications regarding lease violations and interventions to minimize concerns will be in writing and provided to tenant and/or tenant's legal representative and documented in the tenant's record.*

2. Measures taken to ensure the problem does not recur.
    - *The Administrator, Nurse and nurse designee(s) will be re-educated on Tenant Rights and plan of correction.*

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 October 28, 2026.*

Medication Administration

1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.
    - *Medications will be administered as ordered by the physician per the MAR.*
    - *Staff will be delegated by the licensed nurse as required by regulation.*
    - *Medication administration will be documented on the MAR.*

2. Measures taken to ensure the problem does not recur.
    - *The RN and nurse designee will be re-educated on regulations for Medication Administration.*

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

- *Staff delegated to perform medication administration will be retrained on medication administration and documentation on the MAR.*

3. How the Program plans to monitor performance to ensure compliance.
    - *The RN or designee will review medication administration at least every 90-days to ensure compliance.*

4. The date by which the regulatory insufficiency will be corrected.
    - *This plan of correction will be completed on or before October 28, 2026.*

Staffing

1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.
    - *All direct care staff will receive training on service plan tasks.*

2. Measures taken to ensure the problem does not recur.
    - *The RN or nurse designee will be re-educated on required staff training and delegation of tasks.*
    - *All direct care staff will be re-educated on service plan tasks.*

3. How the Program plans to monitor performance to ensure compliance.
    - *The RN or Designee will review staff 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 October 28, 2026.*

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

Sincerely,

Sally Page
Administrator