

DEPARTMENT OF INSPECTIONS AND APPEALS

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>S0384</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>09/24/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ASBURY SUITES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5575 PENNSYLVANIA AVENUE</b><br><b>ASBURY, IA 52002</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| A 000                                                    | <p>Initial Comments</p> <p>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. Number of tenants without cognitive impairment:19<br/>Number of tenants with cognitive impairment:8<br/>Total census:27</p> <p>No regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program, investigation of Complaint #120461-C, Complaint #123553-C and Incident #120344-I.</p> | A 000                                                                                               |                                                                                                                          |                                                                    |

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE