DEPARTMENT OF INSPECTIONS AND APPEALS

ok

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0384	A. BUILDING: _____ B. WING _____	C 07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY SUITES	5575 PENNSYLVANIA AVENUE ASBURY, IA 52002

(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. Number of tenants without cognitive impairment: 14 Number of tenants with cognitive impairment: 9 Total census: 23 The following regulatory insuffiencies were cited during the investigation of Complaint #127162-C.	A 000	see attached poc 8/20/25	
A 145	481-69.22(3) 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 when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the	A 145		

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
	S0384	A. BUILDING: _____ B. WING _____	C 07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY SUITES	5575 PENNSYLVANIA AVENUE ASBURY, IA 52002

(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 145	Continued From page 1 Program failed to evaluate 2 of 4 tenants' functional, cognitive, and health status as needed with significant change (Tenant #1, Tenant C1). Findings include: 1. On 7/15/25, a review of Tenant #1's service plan, dated 5/19/25, revealed a history of potential aggressive behaviors during the overnight hours if staff needed to provide incontinent cares. The service plan showed no other concerns with aggressive behaviors or refusals. A review of physician's orders and physician fax requests revealed a fax, dated 6/19/25, to Tenant #1's physician from the Program's Registered Nurse (RN). The fax revealed the following: Tenant #1 had become more difficult for staff to assist to the restroom with daily refusals. Tenant #1 had begun showing a blank stare toward staff with aggressive behaviors which included incidents where she hit staff. The RN noted on the day before the fax, Tenant #1 had been sleepy and refused staff assistance for toileting and meals. Tenant #1 also skipped breakfast and had a difficult second half of the day. During a transfer on the same day, Tenant #1 removed her hands from staff's and fell backwards hitting her back on her end table. The tenant had no complaints of pain and no injuries were noted. The RN noted on the fax that she had concerns Tenant #1 started to exceed the assisted living level of care due to staff not being able to complete her basic incontinence needs. Tenant #1's physician's orders revealed an order dated 6/24/25 that noted the following: place referral to hospice for palliative care to manage advancing dementia and increase comfort.	A 145		

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
	S0384	A. BUILDING: _____ B. WING _____	C 07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY SUITES	5575 PENNSYLVANIA AVENUE ASBURY, IA 52002

(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 145	Continued From page 2 A review of Tenant #1's nurse's notes showed Tenant #1 was admitted to hospice on 7/2/25 due to her status change. Further review of Tenant #1's record revealed no completed evaluations to assess Tenant #1's functional, cognitive, and health status during this timeframe of increased behaviors and staff assistance. On 7/15/25 at 3:55 pm, the RN confirmed she had not completed any functional, cognitive, or health evaluations on Tenant #1 between 6/1/25 through 7/15/25 to evaluate the increase of behaviors and aggressions. 2. On 7/15/25, a review of C1's record revealed a service plan, dated 1/23/25, noted Tenant C1 used a wheelchair for mobility and required one person assist for transfers. The service plan directed staff to watch for leg swelling and/or difficulty standing. Tenant C1's record revealed a physician order, dated 1/22/25, which revealed a new order to weigh Tenant C1 weekly, elevate legs three times daily for 30 minutes each time, and to begin Lasix 20 mg daily. Tenant C1's nurse's notes revealed the following submissions: 3/10/25 - RN notified Tenant C1 had a notable increase of leg swelling. Staff reported great difficulty transferring Tenant C1 with two staff. The RN wrote in the nurse's notes these were new problem areas over the past week. The RN documented Tenant C1's power of attorney	A 145		

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
	S0384	A. BUILDING: _____ B. WING _____	C 07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY SUITES	5575 PENNSYLVANIA AVENUE ASBURY, IA 52002

(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 145	Continued From page 3 (POA) revealed to the RN during the notification of the increased cares/swelling that Tenant C1 had a torn muscle in her rhomboid muscle. The POA stated she did not want Resident C1 to be seen at the emergency room for assessment. The RN noted she faxed Tenant C1's physician for a request to evaluate for physical therapy/occupational therapy services. 3/24/25 - RN noted Resident C1 was taken to the emergency room for assessment due to chest pain. After discharge from the hospital on 3/25/25, Tenant C1 was admitted into the attached long-term care facility. At the time of admission to the long-term care side of the campus, Tenant C1 required a transfer assist of two staff with a mechanical lift. On 7/15/25 at 3:20 pm, the RN stated she had not evaluated Tenant C1's functional, cognitive, and health status between the dates of 3/10/25 when swelling increased and Tenant C1 began requiring 2 staff assist to discharge on 3/25/25. 4. On 7/15/25 at 4:15 pm the Administrator and RN confirmed the above findings.	A 145		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall 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 treatment, therapy, and medication; and nurses' notes written by exception	A 290		

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
	S0384	A. BUILDING: _____ B. WING _____	C 07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY SUITES	5575 PENNSYLVANIA AVENUE ASBURY, IA 52002

(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 290	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to document in nurse's notes by exception follow-up information regarding laboratory testing results and orders implemented by the physician for 1 out of 4 tenants reviewed (Tenant C1). Findings include: On 7/15/25, a review of Tenant C1's record revealed a nurse's note dated 2/4/25 that Tenant C1's physician was faxed due to her having orange/red foul-smelling urine with an increase in incontinence. Requested an order to collect a urine sample for analysis. Tenant C1's record contained the physician fax order for a urinalysis and culture to be completed. The urinalysis was completed on 2/8/25. Nurse's notes failed to follow-up regarding the results of the urinalysis and what further actions the physician requested/ordered for the signs and symptoms that led to the testing. On 7/15/25 at 3:20 pm, the registered nurse (RN) stated she had not followed up with the tenant or the tenant's family to inquire about any follow-up or new orders after the tenant completed a urinalysis on 2/8/25 and therefore had not documented any follow-up within the nurse's notes by exception. The RN stated the tenant's family took her to her appointments and she was independent in her medication administration at the time of the urinalysis. On 7/15/25 at 4:15 pm, the Administrator and RN confirmed the above findings.	A 290		

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
	S0384	A. BUILDING: _____ B. WING _____	C 07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY SUITES	5575 PENNSYLVANIA AVENUE ASBURY, IA 52002

(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 5	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 update tenants' service plans as needed for 2 out of 4 tenants reviewed (Tenant #1, Tenant C1). Findings include: 1. On 7/15/25, a review of Tenant #1's record revealed an order, dated 6/25/25, requesting a referral for hospice care to aid in medication management for agitation, behaviors, and advancing dementia. A review of Tenant #1's nurse's notes showed Tenant #1 was admitted to hospice on 7/2/25 due to her status change. A review of Tenant #1's service plan dated 5/19/25 showed it had not been updated to include information regarding hospice services as of 7/15/25. On 7/15/25 at 3:55 pm, the registered nurse (RN) stated she had not updated the service plan to reflect the added hospice services to Tenant #1's care.	A 350		

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
	S0384	A. BUILDING: _____ B. WING _____	C 07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY SUITES	5575 PENNSYLVANIA AVENUE ASBURY, IA 52002

(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 6 2. On 7/15/25, a review of Tenant C1's record revealed a service plan dated 1/23/25. Tenant #1's service plan revealed Tenant #1 had an order for a general diet. A review of Tenant C1's physician's orders revealed an order dated 3/3/25 ordering a low potassium diet. The service plan was not updated to include the new diet orders. On 7/15/25 at 3:20 pm, the RN stated she had not updated the service plan to reflect the new diet order for a low potassium diet after 3/3/25. 3. On 7/15/25 at 4:15 pm the Administrator and RN confirmed the above findings.	A 350		

Plan of Correction for Asbury Suites exiting 7-15-25

This serves as the credible allegation of compliance for Asbury Suites, Dubuque Iowa. We assert that all correctives on this plan of correction have been implemented. Regarding the specific deficiencies, we have outlined our corrective actions and continued interventions to ensure compliance with regulations and our plan of action. The staff at Asbury Suites are committed to delivering high quality health care to its residents to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit that Asbury Suites is in substantial compliance as set forth below. We are confident that we will be found in substantial compliance upon re-survey.

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. Asbury Suites has completed the following interventions as a result of the complaint survey ending 7/15/25. The facility will be in substantial compliance by 8/20/25.

A145 481-69.22 (3) EVALUATION OF TENANT

Asbury Suites will ensure that evaluations are completed assessing functional, cognitive, and health status as needed with any significant changes. Tenant # 1 assessments and service plans have been completed. Tenant C1 has been discharged to a long-term care setting. The Assisted Living Director has been re-educated regarding the regulation of assessments being completed timely specific to significant changes and service plans. The Assisted Living Director has completed an audit of the tenants' records to include accurate assessments and updating of service plans. Service plans have been updated accordingly during audit. Concerns identified will be addressed in the facilities quality assurance program for ongoing compliance. The Assisted Living Director will be responsible for ongoing compliance.

A290 481-69.25(1) TENANT DOCUMENTS

Asbury Suites will ensure that documentation is completed per regulatory requirements. Tenant # C1 has been discharged from the facility to a long-term care setting. The facility administrator reviewed with nurses the importance of documenting any changes in a tenant's plan of care. Services plans have been reviewed and updated as needed. The Chief Nursing Officer will randomly audit documentation during his/her visits to the facility to ensure ongoing compliance. Concerns identified will be addressed in the facilities quality assurance program for ongoing compliance. The Assisted Living Director will be responsible for ongoing compliance.

350 481-69.26 (1) SERVICE PLANS Asbury Suites will ensure that service plans are completed and updated per policy and regulations. Tenant # 1 has had their service plan updated. Tenant # C1 has been discharged from the facility to a long-term care facility. The Assisted living director has audited all service plans and updated them accordingly. Ongoing, the ALF Director will audit service plans monthly to ensure all necessary documentation is in place. Concerns identified will be addressed in the facilities quality assurance program for ongoing compliance. The Assisted Living Director will be responsible for ongoing compliance.