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 05/20/2026

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

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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: 10 Number of tenants with cognitive impairment: 17 Total census: 27 Regulatory insufficiencies were cited during the investigation of Incident #131838-I and Complaint #131837-C.	A 000	See attached POC 6/2/26	
A 200	481-67.9(4)f 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: f. Services will be provided to tenants in accordance with the training provided. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to provide services to 1 out of 4 tenants in accordance with the training provided (Tenant #1). Findings follow: Record review on 5/20/26, revealed a medication error report dated 4/01/26 for Tenant #1. The incident report showed Tenant #1 inadvertently	A 200		

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A 200	Continued From page 1 was given Tenant #2's morning medications at 7:15 a.m. The Assisted Living (AL) Registered Nurse (RN) Director and 911 were called immediately. Tenant #1's service plan dated 11/25/26 indicated certified staff were to administer medications to the tenant. Further review of Tenant #1's medication administration record revealed Tenant #1 received her normal medications around 7:00 a.m., which were the following: Amlodipine besylate 2.5 mg 1 tablet, Atorvastatin calcium 80 mg 1 tablet, Farxiga 10 mg 1 tablet, Ferrous sulfate 325 mg 1 tablet, Insulin glargine subcutaneous pen injector 100 unit - 20 units injected, a multivitamin tablet, Wellbutrin SR extended release 12 hr 150 mg 1 tablet, Apixaban 2.5 mg 1 tablet, Furosemide tab 40 mg 2 tablets, Losartan potassium 100 mg 0.5 tablet, Potassium chloride ER 10 meq 2 tablets, Insulin lispro 1 unit dial pen injector 5 units administered, Prochlorperazine maleate 5 mg 1 tablet, and Loreramide hci 2 mg 1 tablet. Further review of Tenant #1's record revealed hospital records dated 4/01/26-4/06/26. The hospital record revealed the following: Tenant #1 was given Narcan and Levophed drip. Poison control indicated to provide supportive care. At 8:46 a.m. on 4/01/26, tenant seemed to be doing better and was alert and oriented. Tenant's family and Program staff indicated Tenant #1 complained of not feeling good the day before. Hospital testing determined she was positive for respiratory syncytial virus (RSV). Tenant was hypotensive and some of her medications were held. Started on Zosyn for RSV. Tenant #1 monitored in the hospital until 4/06/26 at which time she was transferred to the Program's skilled nursing unit to receive occupational and physical therapy prior to returning to her apartment.	A 200		

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A 200	Continued From page 2 Tenant #1's progress notes dated 4/14/26 revealed she returned to her apartment in the assisted living. Record review on 5/20/26, revealed Tenant #2 normally took the following medications during the morning medication pass which were inadvertently given to Tenant #1 on 4/01/26: Buspirone HCl 15 mg 1 tablet, Furosemide 20 mg 1 tablet, Losartan potassium 25 mg 1 tablet, Omeprazole delayed 40 mg 1 capsule, Potassium chloride ER 10 MEQ 1 tablet, Spironolactone 25 mg 1 tablet, Tizanidine HCl 2 mg 1 tablet, Vitamin D3 25 mg 1 capsule, Morphine sulfate ER 30 mg 1 tablet, Propranolol HCl 40 mg 1 tablet, Acetaminophen 500 mg 2 tablets, and Oxycodone HCl oral tab 10 mg 1 tablet. When interviewed on 5/19/26 at 3:46 p.m., Staff A confirmed she passed medications on the morning of 4/01/26. Staff A confirmed she had administered Tenant #1's medications to her around 7:00 a.m., minus her insulin that she would take before breakfast. Staff A reported around 7:15 a.m., she held Tenant #2's morning medications in a cup in her hand and was on her way to administer them in her apartment when she observed Tenant #1's call light on. Staff A added Tenant #1 required assistance with transfers so she thought she should stop in first before she went to Tenant #2's apartment. Staff A entered Tenant #1's apartment and shut the door. Tenant #1 was on the toilet and reported to staff she was ready to go eat breakfast. Staff A placed Tenant #2's cup of medications on the kitchenette countertop in Tenant #1's apartment and went out to the common area around the corner to retrieve Tenant #1's insulin to administer. Staff A returned to Tenant #1's	A 200		

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A 200	Continued From page 3	A 200		

apartment. Staff B was in the room and assisting Tenant #1. Staff B asked Staff A if it was okay that Tenant #1 had more than one cup of water with her pills since she was on a fluid restriction. Staff A stated it had not registered right away, but then realized what Staff B said. Staff A asked what pills did you give her? Staff A looked on the kitchenette countertop and saw Tenant #2's medication cup was gone. Staff A told Staff B she should not be giving any pills to anyone she was not passing medications on her own yet! Staff A told her she had already administered Tenant #1's medications and the cup on the countertop was Tenant #2's medications.
Staff A immediately ran to alert Staff E to call the AL RN Director. Staff A confirmed the AL RN Director was in the unit within 5 minutes and 911 was called. Tenant #1's family and physician were called. Staff A added Tenant #1 had made a comment the day before she had not felt very good.
Staff A confirmed she was delegated by the AL RN Director. Staff A stated she admitted she should not have left medications unattended anywhere. Staff A stated she was trained to always have medications locked up or with her. Staff A confirmed Tenant #1 started to show increased symptoms from the medications in her system but she was not in the area because she had to finish passing medications to the other tenants.

When interviewed on 5/20/26 at 8:37 a.m., Staff E confirmed she worked on the morning of 4/01/26. Staff E stated between 7:00 a.m. and 7:30 a.m., Staff A ran out of Tenant #1's apartment upset and reported she had left Tenant #2's medications sitting in Tenant #1's apartment and Staff B administered those pills to Tenant #1. Staff E called the AL RN Director and she

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A 200	Continued From page 4	A 200		

reported she would arrive in 5 minutes. The AL RN Director called 911 immediately and she instructed staff to take her to the dining table by the Program exit doors to see if Tenant #1 wanted to eat. Staff E stated within 2 minutes of the paramedics arrival, Tenant #1 started to become lethargic and nod forward. The AL RN Director stayed at her side and kept her awake until they arrived. Staff E reported the Program had initially taken Tenant #1's vitals and they were within normal limits. The paramedics also took her vitals and administered Narcan to her as well as start intravenous fluids.
Staff E confirmed she was a medication manager and also passed medications. Staff E reported she was delegated by the AL RN Director on the 5 Rights of a Medication Pass. Staff E stated staff were trained to not leave medications unattended and the staff that prepared medications should be the staff that administered the medications.

When interviewed on 5/20/26 at 9:36 a.m., the AL RN Director recalled Staff E called her as she arrived to work on 4/01/26. She arrived to the unit within 5 minutes of the call. The AL RN Director had Staff A explain the incident. She appeared very panicked. At the time of the AL RN Director's arrival, Tenant #1 appeared fine and had vitals within normal limits. The AL RN Director called the family to confirm sending her to the emergency room for evaluation. 911 was called and shortly before they arrived, Tenant #1 started to nod off to sleep while sitting at the table. The AL RN Director confirmed she stayed at her side and kept her awake. Paramedics administered Narcan upon arrival. Once given Narcan she seemed to perk up. She was taken to the emergency room.
The AL RN Director confirmed Staff A appeared quite upset but Staff B seemed indifferent as if

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A 200	Continued From page 5	A 200		

she was not concerned.
The AL RN Director reported she delegated both Staff A and Staff B to never leave medications unattended and to never allow someone else to administer meds they had not prepared. The AL RN Director added all staff were retrained starting 4/02/26 as they reported to work. Staff A and Staff B's employment was terminated on 4/02/26. The AL RN Director confirmed Staff B was delegated but had not been approved to pas medications on her own yet.

Record review of the internal investigation completed by the Program revealed a statement written by Staff B dated 4/01/26 regarding the incident. Staff B reported she was in Tenant #1's apartment to assist her with the restroom. Staff B reported Staff A came into the apartment with a cup of pills and 2 vials of insulin for someone diabetic. Staff B stated Staff A immediately commented she did not have enough insulin and left the apartment to retrieve more. She left the pills and vials of insulin on the counter. Staff B confirmed she wanted to help out Staff A and went ahead and administered the cup of pills to Tenant #1. Staff B reported Tenant #1 had difficulty swallowing the pills and wanted more water. Staff B asked Staff A if Tenant #1 could have more water since she was on a water restriction. Staff B told Staff A, Tenant #1 had a pill stuck. Staff A asked what pills? Staff B reported to Staff A she administered the cup of pills left on the counter. Staff A exclaimed those were a different tenant's medications. Staff A left the apartment and Staff B finished assisting Tenant #1. The AL RN Director called 911 and Tenant #1 was taken to the emergency room.

Personnel record review on 5/20/26 revealed the following information in Staff A's record: Staff A

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A 200	Continued From page 6 received her medication manager certification on 6/18/25. Staff A was re-delegated by the AL RN Director on 1/19/26. Personnel record review on 5/20/26 revealed the following information in Staff B's record: Staff B received her medication manager certification on 1/21/24. Staff B was delegated by the AL RN Director on 3/02/26 through 3/03/26. Policy record review on 5/20/26, showed a Medication Administration Policy on file which directed certified staff to never leave prepared medications unattended. When interviewed on 5/20/26 at 12:00 p.m., the Administrator and the AL RN Director confirmed Staff A and Staff B failed to pass medications to Tenant #1 in accordance to the training and RN delegations provided.	A 200		
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	A 232		

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A 232	Continued From page 7 Program failed to evaluate 1 out of 4 tenant ' s functional, cognitive and health status with a significant change (Tenant #1). Findings follow: Record review on 5/20/26, revealed a medication error report dated 4/01/26 for Tenant #1. The incident report showed Tenant #1 inadvertently was given Tenant #2's morning medications at 7:15 a.m. The Assisted Living (AL) Registered Nurse (RN) Director and 911 were called immediately. Tenant #1's service plan dated 11/25/26 indicated certified staff were to administer medications to the tenant. Further review of Tenant #1's medication administration record revealed Tenant #1 received her normal medications around 7:00 a.m., which were the following: Amlodipine besylate 2.5 mg 1 tablet, Atorvastatin calcium 80 mg 1 tablet, Farxiga 10 mg 1 tablet, Ferrous sulfate 325 mg 1 tablet, Insulin glargine subcutaneous pen injector 100 unit - 20 units injected, a multivitamin tablet, Wellbutrin SR extended release 12 hr 150 mg 1 tablet, Apixaban 2.5 mg 1 tablet, Furosemide tab 40 mg 2 tablets, Losartan potassium 100 mg 0.5 tablet, Potassium chloride ER 10 meq 2 tablets, Insulin lispro 1 unit dial pen injector 5 units administered, Prochlorperazine maleate 5 mg 1 tablet, and Loreramide hci 2 mg 1 tablet. Further review of Tenant #1's record revealed hospital records dated 4/01/26-4/06/26. The hospital record revealed the following: Tenant #1 was given Narcan and Levophed drip. Poison control indicated to provide supportive care. At 8:46 a.m. on 4/01/26, tenant seemed to be doing better and was alert and oriented. Tenant's family and Program staff indicated Tenant #1 complained of not feeling good the day before.	A 232		

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A 232	Continued From page 8 Hospital testing determined she was positive for respiratory syncytial virus (RSV). Tenant was hypotensive and some of her medications were held. Started on Zosyn for RSV. Tenant #1 monitored in the hospital until 4/06/26 at which time she was transferred to the Program's skilled nursing unit to receive occupational and physical therapy prior to returning to her apartment. Tenant #1's progress notes dated 4/14/26 revealed she returned to her apartment in the assisted living. Tenant #1's record lacked evaluations completed upon her return to the assisted living. Record review on 5/20/26, revealed Tenant #2 normally took the following medications during the morning medication pass which were inadvertently given to Tenant #1 on 4/01/26: Buspirone HCl 15 mg 1 tablet, Furosemide 20 mg 1 tablet, Losartan potassium 25 mg 1 tablet, Omeprazole delayed 40 mg 1 capsule, Potassium chloride ER 10 MEQ 1 tablet, Spironolactone 25 mg 1 tablet, Tizanidine HCl 2 mg 1 tablet, Vitamin D3 25 mg 1 capsule, Morphine sulfate ER 30 mg 1 tablet, Propranolol HCl 40 mg 1 tablet, Acetaminophen 500 mg 2 tablets, and Oxycodone HCl oral tab 10 mg 1 tablet. When interviewed on 5/20/26 at 10:37 a.m., the AL RN Director confirmed she had not completed any evaluations upon Tenant #1's return from her hospitalization and short stay in the skilled nursing facility for strengthening. When interviewed on 5/20/26 at 12:00 p.m., the Administrator and the AL RN Director confirmed no evaluations were completed upon Tenant #1's return to the assisted living program on 4/14/26.	A 232		

PLAN OF CORRECTION FOR ASBURY SUITES

FOR SURVEY ENDING 5/20/26

This serves as the credible allegation of compliance for Asbury suites, assisted living, in 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 of Asbury is 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, assisted living, 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, an assisted living facility in Dubuque, Iowa, has completed the following interventions as a result of the survey ending on 5/20/26. The facility will be in substantial compliance on June 2, 2026.

A 200 481-67.9(4) Staffing

Asbury Suites will ensure that the nurse delegation procedures are followed for certified and non-certified staff. All staff who pass medications have received adequate training, and delegations are followed in accordance with policy and regulations. The Assisted Living Director (RN) has provided re-education to all medication managers and completed new delegation checklists with those passing medications. Both employees who were responsible for the medication error were terminated on 4/02/26. All staff who pass medications were immediately re-educated on the “5 rights of medication pass” following the error. Any new employees who are delegated to pass medications will receive this education along with their delegation checklist. The Assisted Living Director will complete random medication audits of medication passes to ensure ongoing compliance. Concerns identified will be reported and addressed in the facility's quality assurance program. The Assisted Living Director is responsible for ongoing compliance.

A 232 481-69.22(3) EVALUATION OF TENANT

Asbury Suites will ensure that assessments are completed timely per policy and regulation. Each evaluation will assess the tenant's functional, cognitive, and health status as needed with significant change, but not less than annually. The Chief Nursing Officer re-educated the Assisted Living Director on the process of completing significant change assessments at the time of the survey. Resident # 1 has been re-assessed and is back at baseline. The Assisted Living Director has created a spreadsheet of assessments that are due, and a QAPI (Quality Assurance Action Plan) has been developed. The Assisted Living Director knows and understands what

constitutes a “significant change” of status assessment. Assessments will be completed by the ALF director or delegated nurse in the future. Concerns identified will be reported and addressed in the facility's quality assurance program. The Assisted Living Director is responsible for ongoing compliance.