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
	S0301	A. BUILDING: _____ B. WING _____	C 12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISI VILLAGE ASSISTED LIVING	1001 ASSISI DRIVE DUBUQUE, IA 52001

(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: 34 Tenants with cognitive impairment: 2 Total census: 36 No regulatory insufficiencies were cited during the investigation of Incident # 130188-I. The following regulatory insufficiency was cited during the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program.	A 000	See attached POC 12/31/25	
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the Program failed to include the tenant's identified needs on the service plan for 1 out of 4 tenants reviewed (Tenant #1). Finding follows: Record review on 12/03/25, revealed Tenant #1's file indicated an admission date of 8/24/21. Tenant #1's most recent service plan on file was dated 8/01/25. Tenant #1's service plan listed her	A 395		

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

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 395	Continued From page 1 as independent with the use of a walker. A review of Tenant #1's incident reports on file revealed the following incidents: a.) On 9/16/25, Tenant #1 had a fall with no injuries. b.) On 10/11/25, Tenant #1 had a fall and received two small skin tears to her left arm. c.) On 11/9/25, Tenant #1 had a fall with no injuries. Tenant #1's service plan was not updated to include Tenant #1's fall history or identified needs to prevent falls. When interviewed on 12/03/25 at 2:09 p.m., the Registered Nurse Manager confirmed the service plan for Tenant # 1 was not updated to include her fall history and prevention for further falls. When interviewed on 120/3/25 at 3:00 p.m., the Executive Director of Health Services and the Registered Nurse Manager confirmed the above findings.	A 395		

Tag Cited: A395/481-69.26(4)a Service Plans

Issue Cited:
"Service Plans"

Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.

1.) **Immediate actions taken for the resident(s) affected:**
The RN Nurse Manager updated the resident's service plan to reflect fall risk.

2.) **Actions taken/systems implemented to reduce the risk of future occurrences:**
The RN Nurse Manager reviewed the process for updating service plans to ensure fall risk is consistently identified and incorporated when indicated. (See the attached Falls Prevention and Response Policy which has been updated to include the revised process). Additionally, all clinical staff are required to review/receive education on the updated Falls Prevention and Response Policy.

3.) **Monitoring to ensure corrective actions are sustained:**
The RN Nurse Manager will conduct quarterly reviews and audits of resident service plans to verify that fall risk is appropriately identified and addressed. New staff receiving delegations will review service plan and expectations around fall prevention/management.

Corrective action completion date: 12/31/2025