

TERRY E. BRANSTAD
GOVERNORKIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

May 6, 2015

Ms. Paula Padavich, Director
Bryhl Assisted Living
7511 University Avenue
Cedar Falls, IA 50613**RE: Final Recertification Monitoring Evaluation Report – Bryhl Assisted Living, Cedar Falls, IA**

Dear Ms. Padavich:

Enclosed is the **Final Recertification Monitoring Evaluation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following a survey by DIA on **April 27 - 29, 2015**. The Report notes Regulatory Insufficiencies in the area(s) of: Food Service.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Also enclosed you will find the Assisted Living Program Certificate **S0251** with effective dates of **February 15, 2015** through **February 14, 2017**.

If you have any questions in regard to this report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/29/2015
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NAME OF PROVIDER OR SUPPLIER BRYHL ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 7511 UNIVERSITY AVENUE CEDAR FALLS, IA 50613
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A 000	481-67 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. General Population Program Number of tenants without cognitive disorder: 38 Number of tenants with cognitive disorder: 1 Total Population of Program at time of on-site: 39 TOTAL census of Assisted Living Program: 39 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program:	A 000		
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DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

TITLE

(X6) DATE

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DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Paula Harrison RV

TITLE

Director of Assisted Living 5/4/15

(X6) DATE

DATE FORM

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If continuation sheet 1 of 6

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