ASB ALP Monitor's Report & Documentation

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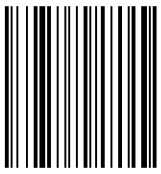

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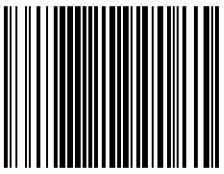

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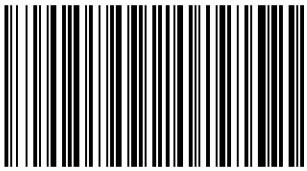

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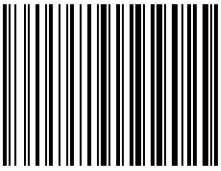

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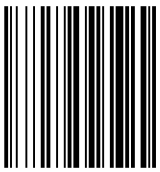

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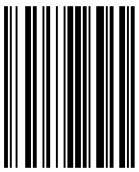

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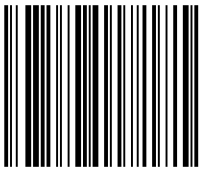

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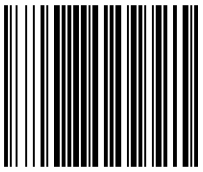

COUNTY

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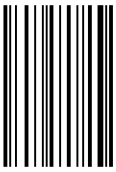

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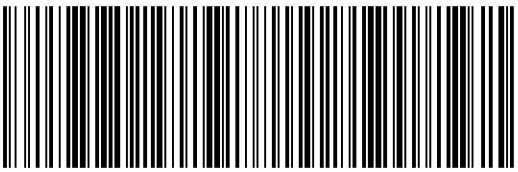
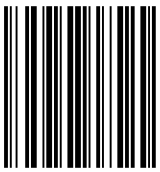


ADULT SERVICES BUREAU

Program



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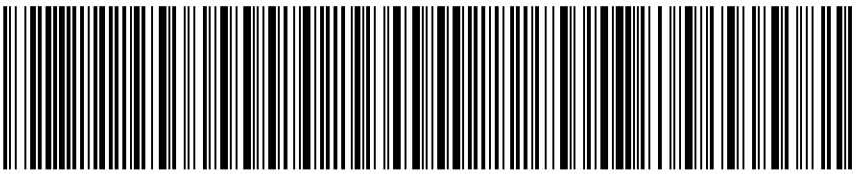
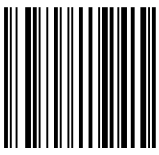


07 - Monitor's Report & Documentation

Exp. Date



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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
	S0251	A. BUILDING: ______ B. WING ______	04/24/2019

8/8/19

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYHL ASSISTED LIVING	7511 UNIVERSITY AVENUE CEDAR FALLS, IA 50613

(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. Number of tenants without cognitive disorder: 28 Number of tenants with cognitive disorder: 3 TOTAL census of Assisted Living Program: 31 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program:	A 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The plan of correction constitutes the facility's credible allegation of compliance such that all alleged deficiencies have been or will be corrected. POC 8/1/19	
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow policy and procedure regarding the completion of incident reports for a medication errors. This pertained to 1 of 4	A 003	481-67.2 Program Policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by the program. All programs shall have policies and procedures related to the reporting of incidents including allegations of abuse.	

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A 003	Continued From page 1 tenants reviewed (Tenant #4). Findings follow: 1. Record review on 4-24-19 of Tenant #4's file revealed diagnoses included: congestive heart failure, atrial fibrillation and hypertension. The service plan indicated staff administered oral medications. Tenant Care Notes indicated the following: a. On 3-4-19 Tenant #4 was admitted to the hospital on 3-2-19 for a urinary tract infection, pneumonia and sepsis. b. On 3-6-19 Tenant #4 returned to the Program. c. On 3-8-19 discharge hospital orders were received and included: Azithromycin 500 milligram (mg) daily for seven days and Prednisone 20 mg, take two tablets, orally for five days. Pharmacy was faxed. d. On 3-12-19 Azithromycin and Prednisone had not been received from pharmacy. e. On 3-14-19 the primary care provider (PCP) was made aware of the medication delay from pharmacy and that medications were started upon arrival. 2. Continued record review revealed hospital discharge records indicated Tenant #4 was admitted to the hospital from 3-2-19 to 3-6-19 with healthcare associated pneumonia. Azithromycin and Augmentin would be continued for 5 more days. Tenant #4 was also given Prednisone and it would be continued for five more days. The discharge summary was noted on 3-8-19.	A 003	481-67.2(231B,213C,231D) To remain in compliance with the above regulation the facility has taken the following action: The policy and procedure for Incidents and Reporting Tenants has been reviewed and amended in the final paragraph of page one and section D of page two to reflect/clarify that the form used in the case of a medication error is the Medication/Treatment Error or Omission Report and not the Incident report form used for other occurrences such falls, etc. 7/17/2019 The Medication/Treatment or Omission Error Report Form is utilized and will continue to be the process for documentation of all med errors including those related to pharmacy. Staff will monitor for pertinent information from this tenant and all tenants upon their return from a hospitalization in order to capture new orders and ensure orders are followed. Should pharmacy be delayed in providing medications then the pharmacy emergency medication supply will be utilized. The Director of Assisted Living will monitor hospital readmission process regularly and bring to the CQI Committee which meets quarterly to ensure compliance with this deficiency. 7/17/2019	7/17/2019 7/17/2019

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 003	Continued From page 2 3. Further record review of the March 2019 medication administration records (MARs) reflected Prednisone 20 mg, take two tablets daily for five days was transcribed on the MAR with a date of 3-8-19. The first recorded dose of Prednisone given was on 3-13-19. Azithromycin 500 mg, take one tablet orally daily for seven days was transcribed on the MAR with a date of 3-8-19. The first recorded dose of Azithromycin given was on 3-11-19 (from the E-Kit). New March MARs were developed and reflected Prednisone 20 mg, take two tablets, orally, daily for five days was documented as given from 3-13-19 to 3-17-19. Azithromycin 500 mg, take one tablet, orally, at bedtime for seven days was documented as given from 3-13-19 to 3-17-19. 4. Continued record review revealed a Provider Communication Form dated 3-11-19 reflected the PCP inquired if Prednisone was not given as it was on the MAR but had not been marked as given. A Provider Communication Form dated 3-12-19 reflected a response from the Program that indicated the orders for Prednisone and Azithromycin were not received until 3-8-19. Pharmacy was faxed but did not send them and staff did not tell a nurse they had not arrived. The medication would be started as soon as they arrived from pharmacy. 5. Further record review revealed incident reports for the last three months were reviewed and an incident report was not completed related to the issue noted above with Tenant #4's medications. Continued record review revealed the Program's	A 003	481-67.2 Program policies and procedures continued. 481-67.2(231B,231C,231D) Program policy for Incidents and Reporting Tenants was updated to reflect the use of Medication/Treatment Error or Omission Report in the event of a medication error. The Medication/Treatment or Omission Error Report Form is and will continue to be utilized in the process of documentation of all med errors/omissions including pharmacy errors. Staff will monitor for information upon return from a hospitalization and a nurse will ensure new orders are followed, documented and ordered from pharmacy. Should pharmacy be delayed in providing medication as ordered the facility pharmacy E-Kit will be used to fulfill said order and ensure tenants receive medication as ordered by the physician. The director of Assisted Living will monitor hospital readmission process regularly and bring to the CQI Committee which meets quarterly to ensure compliance with this deficiency. 7/17/19	7/17/19

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A 003	Continued From page 3 policy and procedure regarding Incidents and Reporting Tenants revealed: a minor incident included an occurrence that involved a tenant during the provision of services that was not a major incident. It included a prescription medication error. Major and minor incidents were to be written on the AL incident report form. 6. When interviewed on 4-24-19 at 4:37 p.m. the Director of Assisted Living confirmed an incident report was not completed for the issue noted above with Tenant #4's medication. In summary, post hospitalization with admitting diagnoses including pneumonia and sepsis, Tenant #4 did not receive Prednisone as ordered from 3-8-19 (when the order was received) until 3-13-19. Tenant #4 did not receive Azithromycin as ordered from 3-8-19 (when the order was received) until 3-11-19. Tenant #4 returned to the Program on 3-6-19; however hospital discharge summary orders were not provided and noted until 3-8-19. An incident report was not completed related to the medication errors.	A 003	(Continued from page 3) As stated above, the Director of Assisted Living will continue to monitor this process regularly and will bring to the CQI Committee which meets quarterly to ensure compliance with this deficiency.7/17/2019 Staff will be educated on what constitutes a medication error/omission and the process to be followed. The Director of Assisted living will monitor regularly this process and bring to the quarterly CQI meeting to ensure compliance with this deficiency. 8/1/2019	7/17/2019 8/1/2019
A 037	481-67.5(6)b Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: b. Medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications.	A 037	481-67.5(6)b Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: b. Medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible	

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A 037	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to store Program administered medications in a secured location only accessible to staff responsible for the administration of medications. This pertained to 2 of 6 tenants observed during observations of the administration of medications (Tenants #1 and #5). Findings follow: 1. Observation on 4-22-19 at 4:03 p.m. of the evening medication pass revealed the following: Staff A administered medications to five tenants during the medication pass observation, including Tenant #5. Tenant #5 had an order for Artificial Tears, 0.5-0.6%, instill one drop in each eye, four times daily (morning, noon, evening and bedtime). There was also an order for Restasis Emulsion 0.05%, instill one drop in each eye, twice daily in the morning and evening (separate from other eye drops by five minutes). Upon entering Tenant #5's apartment, Staff A retrieved Tenant #5's eye drops from an unlocked drawer in the living area. The Artificial Tears was stored in a red cup in the drawer and the Restatis was stored in a blue cup in the drawer, as identified by Staff A. Staff A administered both the Restatis and Artificial Tears (five minutes apart) and then signed off the medications on the medication administration record. Continued observation on 4-23-19 at 4:29 p.m. of the evening medication pass revealed the following: Staff B administered an eye drop to one tenant (Tenant #1) during the the medication pass observation. Tenant #1 had an order for	A 037	481-67.5(b) Medications. (continued) For the administration or storage of such medications. A lockable container was provided by the program for Tenant #5 and both the Artificial tears and the Restasis eye drops are now being kept in the lock box with a key only accessible to staff who administer said eye drops. 4/31/2019	4/31/2019

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 037	Continued From page 5 Latanoprost Solution 0.005%, instill one drop in each eye every evening. Upon entering the apartment Staff B could not locate the Latanoprost eye drops for administration. A family member in the apartment retrieved a new bottle of eye drops from Tenant #1's refrigerator and handed the bottle to Staff B. Staff B then administered one drop in each eye and placed the bottle of the eye drops in a basket located on the table next to Tenant #1's chair before leaving the apartment. 2. Record review revealed the Program's Medication policy and procedure indicated the Program would store all medications administered by the Program in a locked storage area only accessible to staff responsible for administering medications. 3. When interviewed on 4-24-19 at 4:37 p.m. the Director of Assisted Living revealed Tenant #1's eye drops were kept on the table and Tenant #5's eye drops were kept in a drawer.	A 037	481-67.5(6)b Medications (continued) A lockable container was provided by the program for Tenant #1 and the Lantanoprost solution 0.005% eye drops are now kept in the lock box with a key only accessible to staff who administer said eye drops. 4/31/2019 A review of medications administered by the program was completed by the Director of Assisted Living and all medications administered by the program are either stored in the locked medication cart or in secured lock boxes with keys only accessible to those who administer medications. The Director will continue to regularly monitor to ensure all medications administered by the program will be locked in either the medication cart or a lock box with access only to those who administer the medications. The Director of Assisted Living will this process and bring to the CQI Committee which meets quarterly to ensure compliance with this deficiency. 4/31/2019	4/31/2019
A 071	481-69.25(1)i Tenant Documents 481-69.25(231C) 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 071		4/31/2019

DEPARTMENT OF INSPECTIONS AND APPEALS

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071	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurses notes by exception for 4 of 4 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. Record review on 4-23-19 of Tenant #1's file revealed Tenant Care Notes dated 12-29-18 reflected Tenant #1 shivered uncontrollably, wheezing was noted and family reported he had a productive cough. Tenant #1 was sent to the emergency room (ER) on 12-29-18. Continued record review failed to produce a nurses note when Tenant #1 returned from the hospital to indicate when he returned, if there were any new orders or diagnosis. 2. Record review on 4-23-19 of Tenant #2's file revealed the service plan reflected Tenant #2 had a lower left extremity wound related to peripheral edema. Neosporin ointment was to be applied and a nonadherent pad was to cover the wound until healed. Continued record review revealed a Provider Communication Form dated 4-2-19 indicated orders including: a daily assessment of Tenant #2's wound and to call if there were signs of infection. Further record review revealed Tenant Care Notes documented an assessment of the wound daily from 4-8-19 to 4-15-19. The next entry in notes regarding the wound assessment was dated 4-22-19. It was noted on 4-22-19 there	A 071	481-69.25(1)I Tenant documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When 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. 1. To remain in compliance with the above regulations the facility will take the following action: Tenants who have been hospitalized and return to Assisted Living will have documentation upon return to ensure any changes in treatment, medications, and new diagnosis have been captured and documented as such. The Director of Assisted Living will monitor this process regularly and will bring to the CQI Committee which meets quarterly to ensure compliance with this deficiency. 7/22/2019 2. To remain in compliance with the above regulation the facility will take the following action: A policy and procedure will be developed to address at a minimum weekly documentation of wounds unless otherwise ordered by the physician.	7/22/2019

DEPARTMENT OF INSPECTIONS AND APPEALS

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071	Continued From page 7 was a pinpoint scab present without drainage or signs/symptoms of infection. Nurses notes were not completed regarding the daily assessment of Tenant #2's wound as ordered. 3. Record review on 4-24-19 of Tenant #3's file revealed the service plan was updated on 2-6-19 to reflect assistance from Hospice and frequency of services. Tenant Care Notes did not reveal a nurses note corresponding to the update to the service plan on 2-6-19. 4. Record review on 4-24-19 of Tenant #4's file revealed Tenant Care Notes indicated the following: a. On 2-4-19 it was noted Tenant #4 coughed up bright red sputum and her nose started to bleed heavily. Tenant #4 was sent to the ER by ambulance. Further record review failed to produce a nurses note when Tenant #4 returned from the hospital to indicate when she returned, if there were any new orders or diagnosis. b. On 2-16-19 it was noted Tenant #4 had an emesis, complaints of dizziness and began to dry heave. Tenant #4 requested to go to the hospital and was transported by ambulance. A nurses note was not completed when Tenant #4 returned from the hospital to indicate when she returned, if there were any new orders or diagnosis. 5. When interviewed on 4-24-19 at 4:37 p.m. the	A 071	(Continued) The Director of Assisted Living will monitor compliance regularly and will bring to the CQI Committee which meets quarterly to ensure compliance with this deficiency. 3. To remain in compliance with the above regulation the facility will take the following action: A nurse note will be made to reflect any corresponding changes to the tenant service plan. 4. To remain in compliance with the tenant documents regulation the facility will take the following action: Tenants who have been hospitalized and return to Assisted Living will have documentation upon return to ensure any Changes in treatment, medications, and new diagnosis have been captured and documented as such. The Director of Assisted Living will monitor this process regularly and will bring to the CQI Committee which meets quarterly to ensure compliance with this deficiency. 7/22/2019	7/22/2019

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYHL ASSISTED LIVING	7511 UNIVERSITY AVENUE CEDAR FALLS, IA 50613

(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 071	Continued From page 8 Director of Assisted Living confirmed all nurses notes for the tenants listed above were provided.	A 071		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) 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 interview and record review the Program failed to develop a service plan that reflected the identified needs of a tenant. This pertained to 1 of 2 tenants reviewed with recent hospitalizations (Tenant #4). Findings follow: 1. Record review on 4-24-19 of Tenant #4's file revealed diagnoses included: type 2 diabetes mellitus, dementia, hypertension, atrial fibrillation and congestive heart failure (CHF). Provider Progress Notes (Nursing Facility Visit) dated 3-25-19 reflected Tenant #4 had several hospitalizations recently for pneumonia, atrial fibrillation and CHF. Tenant #4 had daily weights and a 1800 milliliters fluid restriction. It indicated she was non-compliant with the fluid restriction. Her prior Primary Care Provider (PCP) recommended a higher level of care and she refused. Tenant #4 was a high risk of readmission (hospital) due to her non-compliance. It also reflected Tenant #4 had an order for Nitroglycerin 0.4 milligram sublingual,	A 089	481-69.26(4)a Service Plans 481-69.26(231C) 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 To remain in compliance with the above regulation the facility will take or has taken the following action: Tenant #4 – A Significant Change Service Plan was completed on 5/8/19 to reflect tenant's noncompliance with the fluid restriction, daily weights and order for Nitroglycerin, additional diagnosis. A corresponding nurse review was completed at that time. 5/5/2019 The Director of Assisted Living will continue to monitor compliance regularly regarding tenant service plans for the reflection of individual needs and preferences and bring to the CQI Committee which meets quarterly to ensure compliance. 8/1/2019	5/5/2019 8/1/2019

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
	S0251	A. BUILDING: _____ B. WING _____	04/24/2019

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BRYHL ASSISTED LIVING	7511 UNIVERSITY AVENUE CEDAR FALLS, IA 50613

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A 089	Continued From page 9 take one tablet every five minutes as needed for chest pain (three dose maximum). Continued record review revealed Tenant Care Notes dated 4-15-19 reflected Tenant #4 went to a Pulmonology appointment, complained of chest pain and was sent to the hospital. Further record review revealed the service plan reflected the fluid restriction; however, did not reflect Tenant #4's non-compliance with the fluid restriction. The service plan also did not reflect Tenant #4's daily weights or the order for Nitroglycerin for chest pain. 2. When interviewed on 4-24-19 at 4:37 p.m. the Director of Assisted Living revealed there were no additional service plan documents for Tenant #4.	A 089		
A 205	481-69.28(6) Food Service 69.28(6) Programs engaged in the preparation and service of meals and snacks shall meet the standards of state and local health laws and ordinances pertaining to the preparation and service of food and shall be licensed pursuant to Iowa Code chapter 137F. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to provide food at required food temperatures. This potentially affected all tenants (census of 31). Findings follow: 1. A community meeting with 10 tenants was held on 4-23-19 at 11:00 a.m. The tenants voiced	A 205	481-69.28(6) Food Service 69.28(6) Programs engaged in the preparation and service of meals and snacks shall meet the standards of state and local health laws and ordinances pertaining to the preparation and service of food and shall be licensed pursuant to Iowa Code chapter 137F	

DEPARTMENT OF INSPECTIONS AND APPEALS

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	S0251	A. BUILDING: _____ B. WING _____	04/24/2019

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A 205	Continued From page 10 concerns with the temperature of the food served and the time it took to be served at meals. The tenants reported daily issues with food temperature, including the hot foods not being served hot. The tenants reported three times per week they waited greater than 15 minutes to be served. 2. Observation on 4-23-19 at 12:15 p.m. to 12:30 p.m. on the second floor dining room revealed all tenants served the lunch meal by 12:30 p.m. The Routine Service Schedule indicated the lunch meal on second floor started at 12:15 p.m. 3. Record review on 4-23-19 revealed the guidelines for Control Temperatures. The following was indicated: a. Cold foods holding at 41 degrees b. Hot foods holding at 140 degrees or higher c. Roast beef at 145 degrees for three minutes d. Pork products at 155 degrees e. All leftovers at 165 degrees f. Poultry and stuffing products at 165 degrees g. Fish and shellfish at 145 degrees h. Fresh egg products at 145 degrees for three and a half minutes i. Hamburger patties 155 degrees for 15 seconds 4. Record review on 4-23-19 of food temperatures for the dining areas located on the first and second floors indicated the following: a. On 4-8-19 (supper) the pea salad was 60 degrees b. On 4-9-19 (lunch) the turkey was 148 degrees, ham was 150 degrees, custard was 60 degrees and milk was 58 degrees c. On 4-9-19 (supper) the sausage patty was 139 degrees	A 205	To remain in compliance with the above regulation the facility will or has taken the following action: The Dietary Manager educated Dietary Staff on 5/31/19 and will further educate Assisted Living staff on the proper serving temperatures for food and what action needs to be taken should food be in the danger zone. The Director of Assisted Living and/or the Dietary Manager will regularly monitor the food temp documentation and bring to the CQI Committee which meets quarterly to ensure compliance with this deficiency. 7/23/19 All Assisted Living staff upon hire are and will continue to be required to complete the Food Safe program though CE Solutions prior to ever serving/assisting with meal service in Assisted Living. 7/17/2019	7/23/2019 7/17/19

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
	S0251	A. BUILDING: _____ B. WING _____	04/24/2019

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A 205	Continued From page 11 d. On 4-12-19 (supper) the coleslaw was 60 degrees e. On 4-13-19 (lunch) the pumpkin fluff was 60 degrees f. On 4-13-19 (supper) the orange creme fruit salad was 63 degrees g. On 4-16-19 (supper) the egg salad was 88 degrees h. An undated temperature recording indicated the baked chicken was at 152.9 degrees i. On 4-19-19 (supper) eggs benedict casserole was 120 degrees, hash browns were 120 degrees, beets were 80 degrees, fruit yogurt parfait was 60 degrees, soup was 130 degrees and the vegetable was 125 degrees j. On 4-22 19 (lunch) the milk was 42 degrees k. On 4-23-19 (lunch) the milk was 43 degrees 5. When interviewed on 4-24-19 at 4:37 p.m. the Director of Assisted Living revealed the food was prepared in the main kitchen (nursing facility) and brought over to the first and second floor dining areas in insulated carts and placed in the steam tables. The temperature of the food was checked in the Program. There had been no issues with food illnesses.	A 205	(Continued from page 11) The Director of Assisted Living and the Assistant Director of Assisted Living will continue to monitor regularly that Food Safe has been completed and will bring to the CQI Committee which meets quarterly to ensure compliance with this regulation. 7/17/19	7/17/19

IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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KIM REYNOLDS
GOVERNOR
ADAM GREGG
LT. GOVERNOR

LARRY JOHNSON, JR., DIRECTOR

June 19, 2019

Paula Padavich, Director of Assisted Living
Bryhl Assisted Living
7511 University Avenue
Cedar Falls, IA 50613

Re: Bryhl Assisted Living Recertification Visit

Dear Ms. Padavich:

A recertification visit was conducted at your program by Stephanie Cummins from 4/22/19 - 4/24/19 determine if the program remains in substantial compliance with certification requirements for an Assisted Living Program

The items of non-compliance found at the time of the recertification visit are listed on the attached Statements of Deficiencies and Plan of Correction forms.

You may complete the State forms by writing your plan of correction in the right hand columns. Please sign and return the completed forms to this office within ten (10) working days of receipt. Retain a copy for your records.

Your Plan of Correction must explain as specifically as possible the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. Measures 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.

All regulatory insufficiencies shall be corrected within 30 days from receipt of the Statement of Deficiencies. Completion dates beyond 30 days from the date of receipt may be accepted if additional documentation is included verifying the need for additional time to achieve compliance and indicating the steps already taken toward compliance.

As provided by IAC rule 481-67.14, you are afforded the opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made in writing to the Department 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.

We wish to thank you and your staff for the courtesies and cooperation extended to our survey staff during their recent visit. If you have any questions regarding this visit, please contact your Program Coordinator.

Sincerely,

Linda Kellen, Bureau Chief
Adult Services Bureau

Catie Campbell

Catie Campbell, Program Coordinator
Adult Services Bureau
515-281-3759
catie.campbell@dia.iowa.gov

Enclosures: Statement of Deficiencies