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
ok 9/5/24	S0251	A. BUILDING: _____ B. WING _____	C 05/23/2024

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 impairment: 30 Number of tenants with cognitive impairment: 0 Total census: 30 No regulatory insufficiencies were cited during the investigations of Complaint #115802-C and Complaint #119303-C. The following regulatory insufficiencies were cited during the investigation of Complaint #120137-C and the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program.	A 000	The statements made on this plan of correction are not an admission to and do not constitute and 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 facilities credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by September 13, 2024.	09/13/24
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to follow established policies related to medication administration for 1 of 4 tenants reviewed (Tenant #3). Finding follows: On 5/21/24 at 9:50 a.m. Tenant #3 spoke of an incident in April when a staff person tried to give her Warfarin (blood thinner) when she wasn't supposed to get it. Tenant #3 explained she was not supposed to take her Warfarin at that time	A 150	481-67.2(3) Program Policies 67.2(3) The program shall follow the policies and procedures established by the program. Tenant #3 Staff A involved in the attempt to administer Warfarin that tenant was not to receive was given a written education on checking the E-MAR prior to administering any medications. Staff B was also instructed not to tell another staff member what HS meds are to be given. On 4/12 Nucara Pharmacist, Mike, was	

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

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 _____	C 05/23/2024

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 150	Continued From page 1 because her INR (international normalized ratio) was too high on that date. Tenant #3 said she did not take the Warfarin offered to her and she told the staff person why she wasn't supposed to take it. Tenant #3 went to the emergency room the following morning, where she was diagnosed with internal abdominal bleeding and admitted to the hospital. On 5/22/24 at 4:30 p.m. Tenant #3 said Staff A came to her apartment to give her Warfarin on the evening she was not supposed to take it. Another staff gave Tenant #3 her other medications earlier that evening. Sometimes the Warfarin arrived at the program later in the evening from the pharmacy, if there was a dosage change due to her INR level. Staff A brought the Warfarin to Tenant #3's apartment and said Staff B told her to give the medication to her. She told Staff A she was not supposed to take the Warfarin because her INR was too high that day. She did not take the medication. After she was hospitalized the next day, the doctor told her she could have died (from abdominal bleeding) if she had taken the Warfarin the evening prior. Record review on 5/23/24 revealed Tenant #3's April Medication Administration Record (MAR), revealed she had an order for Warfarin 1 mg every Monday and Thursday evening, with a start date of 3/28/24 and end date of 4/11/24. She had an order for Warfarin 1.5 mg on the other days of the week, with the same start and end dates. The MAR had a large "X" on the dates when the medication was not supposed to be given on that date. On Thursday, 4/11/24, there was an "X" in the spot for the Warfarin 1 mg, which indicated it should not be given.	A 150	Contacted regarding the card having been set up incorrectly with a tab in the bubble for April 11th. To correct this issue the original order is being faxed to Nucara as well as the order being put into the E-MAR in PCC. A list of “Don’ts” when passing meds was posted for all staff. To further meet 67.2(3), the staff passing meds will be educated and given a copy of the Medication Policy and a copy of the 7 Rights of Medication Administration. These will also be added to the delegation process for passing medications in Assisted Living. Staff will receive education on Warfarin use, side effects and importance of paying close attention regarding such medication.	8/30/24

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 _____	C 05/23/2024

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 150	Continued From page 2 The pharmacy faxed a new patient order form for Tenant #3 to the program on the morning of 4/11/24. The order noted, "Today's INR is 3.7. Patient will HOLD warfarin dose 4/11, then take 1.5 mg 4/12 and 4/13 and 1 mg 4/14. Redraw INR Monday, 4/15." Tenant #3's nursing progress note on 4/11/24 indicated she had an INR of 3.7 that day. Warfarin should be held that evening and restarted the next day, with dosages listed for 4/12/24 through 4/14/24 and then another INR draw on 4/15/24. On 5/22/24 at 10:25 a.m. the RN explained the pharmacy sent a fax on the morning of 4/11/24, which indicated an elevated INR of 3.7 and to hold the Warfarin dose for 4/11/24. The RN entered the new orders in Tenant #3's electronic record, which automatically transferred the information to the tenant's MAR. The MAR then indicated the Warfarin was discontinued as of 4/11/24 and an "X" on 4/11/24 indicated not to give the medication. The pharmacy sent out a new blister card of Warfarin for the next three days, but the pharmacy made an error and put a Warfarin tablet in the spot for the 11th. The 11th slot should have been empty since the Warfarin was not to be given on 4/11/24. The RN said when she talked with Staff A about the incident, Staff A said she popped the Warfarin tablet out for the 11th and offered it to Tenant #3 on the evening of 4/11/24. Staff A admitted to the RN she failed to check the MAR prior to setting up the Warfarin and offering it to the tenant. The RN said she had talked with Tenant #3 earlier on 4/11/24 regarding the elevated INR and the need to hold the Warfarin on that date. Tenant #3 knew to decline the medication when Staff A took it to her.	A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. Staff A and B regarding tenant #3 Warfarin on 4/11/24 were educated on following policy and procedure with med administration and checking the E-MAR prior to administering medications. Nucara Pharmacy was informed of the error made with the card set up and a pill having been in the April 11th bubble when it was to be held. A posting of medication “Don’ts” was posted which included instructions to check every single med against the E-MAR.	

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 _____	C 05/23/2024

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 150	Continued From page 3 On 5/22/24, the RN provided a picture of the Warfarin blister card dated 4/11/24. The instructions indicated to give one tablet at bedtime until 4/14. The label noted the blister card contained four tabs. (The card should have contained only three tablets, for 4/12, 4/13 and 4/14.) On 5/22/24 at 4:50 p.m. Staff A said she worked on the Assisted Living first floor on the evening of the incident (4/11/24). Staff B worked on the second floor, where Tenant #3 resided. Staff B came to the first floor that evening and asked if the pharmacy had delivered medications yet. The pharmacy had just made a delivery, including Tenant #3's Warfarin. Staff B asked Staff A to give the Warfarin to Tenant #3 because the tenant didn't allow Staff B to enter her apartment. Staff A went to the second floor and set up the Warfarin tablet by popping it out of the new medication blister card the pharmacy delivered. The blister card contained a Warfarin tablet for the 11th. Staff A said she didn't look at Tenant #3's MAR prior to setting up and offering the medication. She said Staff B told her Tenant #3 should get the Warfarin. She took the Warfarin to Tenant #3 in her apartment, but the tenant said she wasn't supposed to get it and refused to take it. Staff A then checked the MAR with Staff B and they saw the Warfarin was discontinued as of that date and should not be given. On 5/22/24 at 5:25 p.m. Staff B said he was the med passer on second floor on the evening of the incident. Tenant #3 didn't allow him to enter her apartment, but he could give her medications to her when she was in a common area, such as the dining room. He had administered her other medications earlier that evening, but he was	A 150	Staff will further be educated on the Assisted Living Medication Policy and the 7 Rights of Medication Administration and will be given a copy of each. These documents will also be added to the delegation process for those passing medications in Assisted Living. Staff will receive education on Warfarin, the side effects and importance of checking orders in the E-MAR before administration.	8/30/24

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 _____	C 05/23/2024

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 150	Continued From page 4 waiting for the Warfarin to arrive from the pharmacy. Tenant #3 was in her apartment by the time the pharmacy delivered the Warfarin, so he asked Staff B to take the medication to her. He didn't notice if Staff A checked the MAR before taking the Warfarin to Tenant #3. Staff A returned with the Warfarin and told him Tenant #3 said she was not supposed to take it. Staff A and Staff B then checked Tenant #3's MAR and saw the Warfarin had been discontinued on that date and she was not supposed to receive it. The program Medication Administration policy indicated staff administering the medication should verify the medication on the MAR and med card, prior to removing the medication from the card and offering it to the tenant. On 5/22/24 at 9:35 a.m. the Director of Assisted Living/Registered Nurse (RN) verified the incident on the evening of 4/11/24 when staff mistakenly offered Tenant #3 her Warfarin. The RN said she re-educated Staff A and Staff B on checking the medication administration record (MAR) prior to passing medications.	A 150		
A 140	481-69.22(2) Evaluation of Tenant 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. 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. This REQUIREMENT is not met as evidenced	A 140	481-69.22(2) Evaluation of Tenant 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall be conducted by a healthcare professional, a human service.	

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 _____	C 05/23/2024

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 140	Continued From page 5 by: Based on interview and record review, the program failed to complete 30-day assessments for 1 of 1 tenant reviewed who moved to the program within the past year (Tenant #2). Finding follows: On 5/22/24 record review revealed Tenant #2 moved to the program on 1/29/2024. The Registered Nurse (RN) completed Tenant #2's initial assessments on 1/26/24. Additional assessments could not be located in Tenant #2's record. On 5/22/24 at 2:30 p.m. the RN confirmed no assessments had been done for Tenant #2 since the initial assessments on 1/26/24.	A 140	Or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. On 5/23/24 a 90 Day Review was completed for tenant #2 with no changes to original assessment or service plan. Reviewed service plan document with tenant. Will complete a full review and service plan by 9/03/24 to bring up to date. All tenant records will be reviewed to ensure accuracy of time lines by 09/13/24	09/03/24 09/13/24
A 360	481-69.26(3) Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to review/update the service plan within 30 days of occupancy for 1 of 1 tenant reviewed who moved to the program within the past year (Tenant #2). Finding follows: On 5/22/24 record review revealed Tenant #2	A 360		

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 _____	C 05/23/2024

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 360	Continued From page 6 moved to the program on 1/29/2024. The Registered Nurse and Tenant #2 signed the initial service plan on 1/29/24, which included personal and health care assistance. No documentation of a review or update to the original service plan could be located in Tenant #2's record. On 5/22/24 at 2:30 p.m. the RN verified Tenant #2's initial service plan had not been reviewed or update since she moved to the program.	A 360		
A 420	481-69.27(1)a Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: a. To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to complete nursing reviews at least every 90 days for 1 of 1 tenants reviewed who moved to the program within the past year (Tenant #2). Finding follows: On 5/22/24 record review revealed Tenant #2	A 420	481-69.27(1) Nurse Review All tenant records to be reviewed for accuracy of time line for assessments and service plans. 90 Day Reviews are being completed on all tenants. Tenant #2 90 day Review was completed on 5/23/24. Medications are reviewed for being current, accuracy and any potential adverse reactions. This is now addressed and documented in each tenant's 90 day review..	09/13/24

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 _____	C 05/23/2024

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 420	Continued From page 7 moved to the program on 1/29/2024. The Registered Nurse (RN) completed Tenant #2's initial assessments on 1/26/24, which included health/medical information. No additional nursing reviews could be located in Tenant #2's record. On 5/22/24 at 2:30 p.m., the RN confirmed no nursing review completed for Tenant #2 since she moved to the program.	A 420		