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 09/18/2024

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: 18 Number of tenants with cognitive impairment: 1 Total census: 19 The following regulatory insufficiency was cited during the investigation of Complaint #123102-C	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 facilities credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by October 31, 2024.	10/31/24
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to ensure medications were administered in accordance with physician's orders for 1 of 3 tenants reviewed (Tenant #1). Finding follows: Record review on 9/18/24 revealed internal investigations of two recent medication errors involving Tenant #1 as follows:	A 285	On August 30, 2024 Med Managers/Certified Med Aides were sent via email a copy of the Assisted Living Medication Policy and instructed to respond that they had received and read the policy.	8/30/24

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 285	Continued From page 1 a. On 8/25/24, Staff A set up Tenant #1's medications for her and included an extra tablet of Tramadol 50 mg. Tenant #1 realized the error and did not take the additional medication. Staff A returned the Tramadol tablet to the medication card and affixed it with tape. Staff A admitted to the error when questioned by the Assisted Living (AL) Director. b. On 9/13/24, Staff B set up Tenant #1's medications for her and included an extra tablet of Tramadol 50 mg. Tenant #1 realized the error and did not take the additional medication. Staff B returned the Tramadol tablet to the medication card and affixed it with tape. Staff B admitted to the error when questioned by the AL Director. On 9/18/24 at 10:45 a.m. Tenant #1 recalled both medication error incidents. She said on 8/25/24 Staff A set up her medications in a medication cup, which he left by her plate at dinner on the evening of 8/25/24. Tenant #1 saw two tablets of Tramadol and she knew she only had one tablet prescribed in the evening. Tenant #1 also had a PRN (as needed) Tramadol 50 mg tablet prescribed every 6 hours for pain, but she had not requested it. Tenant #1 said Staff A came back to get the additional Tramadol tablet, but she wanted to show a nurse to confirm the medication error. Tenant #1 showed a temp agency nurse, who talked with Staff A about the medication error. Regarding the medication error on 9/13/24, Tenant #1 said Staff B brought her evening medications to her, which had two Tramadol tablets. Tenant #1 told Staff B she was supposed to get only one Tramadol and Staff B apologized and took the additional tablet away. On 9/18/24 at 2:00 p.m. the AL Director confirmed	A 285	Staff A was counseled on 8/28/24 regarding the mistaken attempt to give Tenant #1 two Tramadol 50 mg. The Med Administration policy, the 7 Rights of Medication and the need to document immediately in the Narcotic count Book as per policy when a controlled substance is being administered were addressed. Staff A has also been instructed not to administer any medication to Tenant #1. Staff A has been instructed to get another CMA, Med Manager, or a nurse to administer medication to Tenant #1 should the need arise.	8/28/24

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A 285	Continued From page 2 the two medication errors involving Tenant #1's Tramadol on 8/25/24 and 9/13/24. Staff A and Staff B set up two Tramadol 50 mg tablets for Tenant #1, but the order was for one tablet. In both instances, Tenant #1 realized the error and did not take the additional medication. Tenant #1 had an order for PRN (as needed) Tramadol 50 mg every six hours for pain, in addition to the regular order for Tramadol 50 mg three times per day, so taking an additional Tramadol would have been acceptable if she had requested it, but she had not. Tenant #1 had the ability to manage her own PRN and over the counter medications. The AL Director speculated the staff might have become confused because another tenant regularly took two tablets of Tramadol. On 9/18/24 at 5:30 p.m. Staff A verified he mistakenly set up two Tramadol 50 mg tablets in Tenant #1's medication cup on the evening of 8/25/24. Staff A left the medication for Tenant #1 and realized as he filled out the narcotic count sheet for the Tramadol at the medication cart that he made a mistake. He returned to retrieve the additional Tramadol tablet, but Tenant #1 initially refused to give it to him until she showed a nurse. Tenant #1 did not take the additional medication. Record review revealed Tenant #1 had a physician's order for Tramadol 50 mg, one tablet three times per day for pain, given in the morning, noon and evening. Tenant #1 also had an order for Tramadol 50 mg, one tablet every six hours as needed for pain. Review of Tenant #1's August and September medication administration records (MAR) revealed she regularly received the Tramadol three times per day and did not receive any doses of PRN Tramadol. Staff recorded the number of remaining Tramadol on count sheets after administering each dose.	A 285	Staff B was given a counseling over the phone 9/13 regarding the setting up of two tabs of Tramadol 50 mg on 9/13/24 which the tenant then did not take. Staff B came into the facility and further discussed the 9/13 med concern formally on 9/19 and was given a copy of the Med policy, 7 Rights of Med Administration and instructed that as per the Med Administration Policy, when a controlled substance is removed from the card, it should be documented immediately in the Narcotic Count Book before being administered to the tenant. The Med Administration Policy, 7 Rights of Administration and the need to immediately document in the Narcotic Count binder were addressed during the phone call and the formal counseling.	9/19/24

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A 285	Continued From page 3 Medication policy last updated 6/18/24 noted the seven rights of medication administration, which included the right drug and right dose. The procedures section directed staff to verify the medication information on the E-MAR (electronic medication administration record) before punching the medication out of the medication card and setting it up in the medication cup.	A 285	The RN/Director of Assisted Living will conduct random audits and monitoring of proper medication administration to monitor performance and ensure compliance. The Medication Policy, 7 Rights of Administration and proper documentation of controlled substances will be reviewed at the time the random audits are completed.	10/31/24