STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165587	A. Building B. Wing	07/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northbrook Healthcare and Rehabilitation Center	6420 Council Street NE Cedar Rapids, IA 52402

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 48452 Based on observation, clinical record review, a written grievance, and staff, resident, and family interviews the facility failed to provide consistent restorative cares to prevent decline in mobility and/or range of motion for 3 of 4 residents reviewed (Residents #1, #2, #3). The facility reported a census of 77 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #1 dated 5/31/24 documented diagnoses of hemiplegia following cerebral infarction (stroke) affecting the left side, weakness, and arthritis. MDS Section C documented a Brief Interview for Mental Status (BIMS) of 12/15, indicating moderate cognitive impairment. Section GG documented the resident required a walker or wheelchair for mobility, needed substantial to maximal assistance with bed mobility, and was dependent on 2 or more helpers for sit to stand and transfers. The resident did not have a history of using a mechanical lift. Resident #1's Care Plan revealed a focus area dated 5/24/24 which documented an ADL self care deficit related to limited range of motion and limited mobility. Interventions included assistance of 2 for toileting and transfers, discussion of functional decline with resident and family, use of a bell to call for assistance, and PT/OT to evaluate and treat. It lacked documentation of a plan for regular range of motion activity with the resident or a walking/mobility program to maintain current functioning or prevent a decline in either area. A Progress Note dated 6/5/24 titled Nursing Progress Note revealed staff spoke with the resident regarding increased difficulty transferring. It did not include discussion regarding how to prevent further decline. A complaint letter to the facility dated 6/5/24, addressed to the Director of Nursing and facility management documented Resident #1's family recently learned and was concerned about the use of a mechanical lift during his care. They indicated they were at the facility daily, watched the resident's transfers, and did not receive an explanation or reasoning for the use of the lift. Progress Notes reviewed between 6/1/24 and 6/13/24 provided no documentation regarding the use of the mechanical lift or range of motion treatment or services for the resident to improve or maintain his mobility. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165587	A. Building B. Wing	07/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northbrook Healthcare and Rehabilitation Center	6420 Council Street NE Cedar Rapids, IA 52402

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #1's daughter on 7/20/24 revealed she was at the facility daily while he was there. She stated she observed transfers and use of the walker to the bathroom. She indicated Resident #1 did not ambulate with staff outside of trips to the bathroom for the first 17 days he was there. She also reported she did not see staff work on range of motion with Resident #1 during his stay, nor did staff discuss that with her. On 7/19/24 at 9:27 AM the Administrator stated Staff D initiated a restorative program based on a quality assurance performance improvement (QAPI) project. An interview with Staff D, Activities Director and Certified Medication Aide (CMA), on 7/19/24 at 9:38 AM revealed more structured restorative work started Monday (7/15/24). Staff D stated the facility started discussing restorative work in February or March but had to wait to hire an activity assistant. She stated the program in place before that was 'confusing.' She did not have a formal calendar in place, was not able to provide a written plan, and stated Care Plans were updated. She said residents seemed excited about the new plan to develop a program, especially walking. An interview with Staff A, Certified Nursing Aide (CNA)/CMA on 7/20/24 at 10:35 AM determined she had not been asked to participate in restorative mobility or range of motion work with the residents in her CNA or CMA roles. An interview on 7/20/24 at 10:47 AM with Staff E, Registered Nurse (RN) revealed restorative work should be completed by a restorative nurse or CNA if the facility had one. She stated there was not one until recently. 2. The MDS for Resident #2 dated 4/25/24 documented a BIMS of 12/15 indicating moderate cognitive impairment, and included diagnoses of coronary artery disease, acute respiratory failure with hypoxia (not enough oxygen in tissue), and congestive heart failure. Resident #2's Care Plan included a focus area dated 4/30/24 for ADL self-care performance deficit related to fatigue, impaired balance, limited mobility, pain, fibromyalgia, shortness of breath, and congestive heart failure. It lacked documentation of a plan for regular range of motion activity with the resident or a walking/mobility program to maintain current functioning or prevent a decline in either area. On 7/19/24 at 8:39 AM observed the resident in her room, seated on her bed, eating breakfast. She was still in her pajamas. She stated she could usually get dressed by herself and asked staff if she needed help. Resident #2 stated she did not know what a restorative or range of motion program was. After an explanation she stated she wasn't offered that and staff didn't help her with that. 3. The MDS for Resident #3 dated 6/27/24 documented a BIMS of 15/15 indicating intact cognition, and included diagnoses of coronary artery disease, anemia, and obstructive sleep apnea. Section GG revealed the resident needed assistance with activities of daily living with set up and after the activity. Resident #3's Care Plan included a focus area revised 9/20/23 for ADL self-care performance deficit related to confusion and dementia. It lacked documentation of a plan for regular range of motion activity with the resident or a walking/mobility program to maintain current functioning or prevent a decline in either area. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165587	A. Building B. Wing	07/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northbrook Healthcare and Rehabilitation Center	6420 Council Street NE Cedar Rapids, IA 52402

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #3 on 7/19/24 at 9:02 AM revealed the resident had not been offered range of motion services. She stated she saw someone do it with her roommate once but no one ever helped her stretch like that. She thought that might feel good but the CNA's who helped her did not perform or guide her in those types of exercises. The facility was unable to provide a restorative plan, calendar, training, policy, or facility procedure for maintaining the resident's highest level of functioning for range of motion and/or mobility. On 7/20/24 at 3:17 PM the Director of Nursing stated she was still working on a policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165587	A. Building B. Wing	07/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northbrook Healthcare and Rehabilitation Center	6420 Council Street NE Cedar Rapids, IA 52402

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 48452 Based on record review, policy review, and interviews the facility failed to ensure providers reviewed medications and associated diagnoses for 1 of 3 residents reviewed (Residents #2). During 3 visits in June 2024, including a medication review, the provider did not identify a medication order error. The facility reported a census of 77 residents. Findings include: The Minimum Data Set (MDS) for Resident #2 dated 4/25/24 documented a Brief Interview for Mental Status (BIMS) of 12/15 indicating moderate cognitive impairment, and included diagnoses of acute respiratory failure with hypoxia (not enough oxygen in tissue), sepsis, and congestive heart failure. It did not include a diagnosis of diabetes. The Medication Administration Record (MAR) documented Resident #2 received 77 doses of Glimepiride Tablet 2 MG for diabetes between 4/24/24 and 7/11/24. Progress Notes dated from 3/17/24 through 7/15/24 labeled Order Note lacked orders for the Glimepiride entered into the MAR. A document titled Order Details from the EHR documented the order was entered and confirmed by Staff G, Licensed Practical Nurse, on 4/23/24 at 8:13 PM, and ordered by the resident's current primary physician (ARNP, Advanced Registered Nurse Practitioner). A document titled Routing ICF visit with an encounter date of 6/20/24 indicated the reason for the visit was a review of chronic medical conditions. Number 16 on the assessment list was an encounter for medication review. The list did not include diabetes. The provider documented she completed a review of medications and no changes were made that day. A document titled Acute ICF visit with an encounter date of 6/21/24 revealed the resident was seen for acute encephalopathy (rapidly progressive brain dysfunction). The resident had gone unresponsive with oxygen saturation at 73% on room air. She was unable to answer questions and exhibited nonsensical wording. The medications section documented see facility MAR for current medications and indicated there were no medication changes. A document titled ICF Progress Note with an encounter date of 6/24/24 documented the visit was to review chronic medical conditions. The resident did not remember the events from the past Friday. Family discussed hospice with the provider. The medication section documented see facility MAR for current medications and indicated there were no medication changes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165587	A. Building B. Wing	07/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northbrook Healthcare and Rehabilitation Center	6420 Council Street NE Cedar Rapids, IA 52402

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A document titled ED (Emergency Department) to Hosp (Hospital) admitted d 7/10/24 revealed the resident presented for evaluation of altered mental status and shaking and included documentation of the episode on 6/21/24, chronic headaches for a month and a half, and mild intermittent blurred vision. While in the ED the resident's glucose was 41 and, despite supplementation the glucose remained low. The hospital admission diagnosis was labeled as hypoglycemia. They were uncertain why Glimepiride was added to the medication list and documented it should NOT be prescribed as she did not have a history of diabetes or elevated blood glucose values. A section titled ED Course noted the following blood sugars on 7/10/24: 0624, 34; 0843, 81; 1113, 54 (despite 500 ml of 10% dextrose, breakfast, and several orange juice containers); 1252, 66 (additional bolus of 10% dextrose); 1358, 88; 1459, patient continues to be hypoglycemic despite 2 full meals and 1 L of 10% dextrose). The resident was admitted at that time. An interview with the Director of Nursing on 7/20/24 at 3:17 PM revealed she considered this an unfortunate incident. She was not employed by the facility when the order was entered. She confirmed the facility did not address a new plan for error prevention with their providers until education was provided to them on 7/19/24, and stated the facility did not have a written policy or procedure for medication errors. Staff were expected to follow the physician's orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165587	A. Building B. Wing	07/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northbrook Healthcare and Rehabilitation Center	6420 Council Street NE Cedar Rapids, IA 52402

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 48452 Based on record review, policy review, and interviews the facility failed to ensure pharmacy consultants reviewed medications and associated diagnoses for 1 of 3 residents reviewed (Residents #2). During 3 separate monthly drug regimen reviews the pharmacy consultant failed to find the diabetic medication error for the resident. The facility reported a census of 77 residents. Findings include: The Minimum Data Set (MDS) for Resident #2 dated 4/25/24 documented a Brief Interview for Mental Status (BIMS) of 12/15 indicating moderate cognitive impairment, and included diagnoses of acute respiratory failure with hypoxia (not enough oxygen in tissue), sepsis, and congestive heart failure. It did not include a diagnosis of diabetes. The Medication Administration Record (MAR) documented Resident #2 received 77 doses of Glimepiride Tablet 2 MG for diabetes between 4/24/24 and 7/11/24. Progress Notes dated from 3/17/24 through 7/15/24 labeled Order Note lacked orders for the Glimepiride entered into the MAR. Progress Notes labeled Pharmacy Note indicated the resident's medications were reviewed and failed to address the Glimepiride. They revealed the following: 5/24/24 at 13:59 Note Text: GDRs (gradual dose reductions) sent last month; NC (no change) in meds due to patient is variable with mood. No pharmacy recommendations. 6/21/24 at 19:59 Note Text: MRR (medication regimen review) completed. PRN (as needed) Ativan documentation requested if order is continued > 14 days. 7/10/24 at 14:57 Note Text: MRR completed. No pharmacy recommendations. A document titled Investigation regarding incorrect medication, dated 7/12/24, documented the facility initiated an investigation into the use of Glimepiride for Resident #2 after the resident was admitted to the hospital for hypoglycemia. The document lacked interventions to be put into place with the pharmacy consultant as part of the comprehensive plan. An interview with the Director of Nursing on 7/20/24 at 3:17 PM revealed she considered this an unfortunate incident. She confirmed the facility did not address a plan with the pharmacy, and stated the facility did not have a written policy or procedure for medication errors. During an interview with the Administrator on 7/20/24 at 3:24 PM she acknowledged the initial plan did not address the pharmacy review and had been updated the day before to include the DON working with the consultant when they were in the building to review new medications on a more individual basis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165587	A. Building B. Wing	07/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northbrook Healthcare and Rehabilitation Center	6420 Council Street NE Cedar Rapids, IA 52402

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. 48452 Based on clinical record review, hospital record review, resident and staff interviews the facility failed to prevent a significant medication error from occurring. Resident #2 received Glimepiride 2 mg for 77 days without a diagnosis of diabetes or a physician's order. The nurse on duty at the time the order was received entered another resident's order in this resident's electronic health record (EHR). Over the 77 day timeframe, 11 nurses/Certified Medication Aides (CMA) who administered the medication, the Director of Nursing (DON), the provider (at least 3 visits including a med review visit), and the pharmacy consultant (at least 3 Drug Regimen Reviews) failed to identify the error. These circumstances posed Immediate Jeopardy to resident health and safety. The facility was notified of the Immediate Jeopardy on 7/19/24 at 4:15 PM which began on 4/23/24. The facility took the appropriate action to remove the Immediate Jeopardy on 7/20/24 at 8:29 AM by taking these steps: 1. Put a new process in place for new orders to be double checked by a 2nd nurse. 2. Ensuring newly prescribed medications are reviewed by the pharmacy consultant for appropriateness for that resident. 3. Providers were contacted to discuss emphasis of thorough review of Physician Order Sheets. 4. Medication order audits put in place. 5. DON/designee to audit new processes to ensure expectations are followed. 6. Medication reconciliation added to QAPI agenda. This lowered the scope and severity from a J to a G. The facility reported a census of 77 residents. Findings include: The Minimum Data Set (MDS) for Resident #2 dated 4/25/24 documented a Brief Interview for Mental Status (BIMS) score of 12/15 indicating moderate cognitive impairment. It included diagnoses of coronary artery disease, acute respiratory failure with hypoxia (not enough oxygen in tissue), and congestive heart failure. Section E documented the resident did not exhibit hallucinations or delusions, and did not exhibit physical or verbal behaviors. The resident needed set up and clean up assistance with transfers, and substantial assistance with shower transfers. Section I did not include diagnoses of seizures, epilepsy, or diabetes mellitus. Resident #2's Care Plan included a focus area dated 4/30/24 for ADL self-care performance deficit related to fatigue, impaired balance, limited mobility, pain, fibromyalgia, shortness of breath, and congestive heart failure. Another focus area dated 11/6/23 documented the resident was at risk for falls related to confusion, deconditioning, gait/balance problems, incontinence, poor communication/comprehension, and was unaware of safety needs. An intervention dated 7/10/24 directed staff to rule out physiological causes. The diagnosis list at the end of the Care Plan did not include diabetes or seizures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165587	A. Building B. Wing	07/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northbrook Healthcare and Rehabilitation Center	6420 Council Street NE Cedar Rapids, IA 52402

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Resident #2 on 7/19/24 at 8:39 AM observed her in her room, seated on her bed, and eating breakfast. She was still in her pajamas. She stated she could usually get dressed by herself and asked staff if she needed help. The resident stated she was not diabetic and didn't know how the medication (Glimepiride) was added to her record. She stated staff never told her the medication was added and if staff would have told her she would have said she did not need it. She revealed she was hospitalized with low blood sugar due to the error a little over a week prior. She stated she was scared and said the staff tried to kill her. She said she didn't trust 'them' anymore. She was also upset the facility called it a seizure and stated she never had a seizure in her life. A document titled DON recap of events dated 7/11/24 documented Resident #2 was found on floor in room by nursing staff exhibiting seizure like activity. Resident was found to be hypoglycemic upon admission to hospital that continued to fluctuate. Hospital reached out to facility inquiring about indication for Glimepiride on patient's medication list and prescribing provider due to patient not having current diagnosis of diabetes. It was discovered at this time that pharmacy received prescription transmission from the Electronic Health Record (EHR) for medication due to agency nurse entering order into EHR, and it was not electronically prescribed by any physician. Administration reached out to (Staff G, Licensed Practical Nurse) who entered the order, and she could not recall specific order entry, and stated if I put that in, then the order should be there because I noted it after it came through. It was identified that another patient on hallway had written orders for this drug, and was also entered in the EHR. Further record review revealed the following: The Medication Administration Record (MAR) documented Resident #2 received 77 doses of Glimepiride (anti-diabetic medication used to treat high blood sugar levels caused by diabetes) Tablet 2 MG for diabetes between 4/24/24 and 7/11/24. Progress Notes dated from 3/17/24 through 7/15/24 labeled Order Note lacked orders for the Glimepiride entered into the MAR. A document titled Order Details from the EHR documented the order was entered and confirmed by Staff G, Licensed Practical Nurse, on 4/23/24 at 8:13 PM, and ordered by the resident's current primary physician (ARNP, Advanced Registered Nurse Practitioner). A document titled Medical Facsimile Cover Sheet dated 4/23/24 documented another resident in the facility, Resident #5, received an order for Glimepiride 2 mg. It was initialed by the nurse on 4/24/24 with a note that said MAR updated. Progress Notes for Resident #2 labeled Pharmacy Note indicated the resident's medications were reviewed and failed to address the Glimepiride. This included: 5/24/24 at 13:59 Note Text: GDRs (gradual dose reductions) sent last month; NC (no change) in meds due to patient is variable with mood. No pharmacy recommendations; 6/21/24 at 19:59 Note Text: MRR (medication regimen review) completed. PRN (as needed) Ativan documentation requested if order is continued > 14 days; and 7/10/24 at 14:57 Note Text: MRR completed. No pharmacy recommendations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165587	A. Building B. Wing	07/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northbrook Healthcare and Rehabilitation Center	6420 Council Street NE Cedar Rapids, IA 52402

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A document for Resident #2 titled: Routing ICF visit with an encounter date of 6/20/24 indicated the reason for the provider visit to the facility was a review of chronic medical conditions. Number 16 on the assessment list was an encounter for medication review. The list did not include diabetes. The provider documented they completed a review of medications and no changes were made that day. A document for Resident #2 titled: Acute ICF visit with an encounter date of 6/21/24 revealed the resident was seen at the facility for acute encephalopathy (rapidly progressive brain dysfunction). The resident had gone unresponsive with oxygen saturation at 73% on room air. She was unable to answer questions and exhibited nonsensical wording. The medications section documented see facility MAR for current medications and indicated there were no medication changes. A document for Resident #2 titled: ICF Progress Note with an encounter date of 6/24/24 documented the facility visit was to review chronic medical conditions. The resident did not remember the events from the past Friday. Family discussed hospice with the provider. The medication section documented see facility MAR for current medications and indicated there were no medication changes. A Progress Note dated 7/10/24 at 6:01 AM titled Nursing Progress Note documented Resident had her call light on, Certified Nurse Aide (CNA) said resident was on the floor shaking and her speech was incoherent. Nurse called 911. Nurse call 911. Resident was taken to (local hospital). A note 7/11/24 at 7:31 AM titled Orders Administration Note indicated the resident was hospitalized . A document titled ED (Emergency Department) to Hosp (Hospital) admitted d 7/10/24 revealed Resident #2 presented for evaluation of altered mental status and shaking and included documentation of the episode on 6/21/24, chronic headaches for a month and a half, and mild intermittent blurred vision. While in the ED the resident's blood glucose was 41 and, despite supplementation the glucose remained low. The hospital admission diagnosis was labeled as hypoglycemia. They were uncertain why Glimepiride was added to the medication list and documented it should NOT be prescribed as she did not have a history of diabetes or elevated blood glucose values. A section titled ED Course noted the following blood sugars on 7/10/24: 0624, 34; 0843, 81; 1113, 54 (despite 500 ml of 10% dextrose, breakfast, and several orange juice containers); 1252, 66 (additional bolus of 10% dextrose); 1358, 88; 1459, patient continues to be hypoglycemic despite 2 full meals and 1 L of 10% dextrose. The resident was admitted at that time. An interview with Staff A, CMA, on 7/20/24 at 10:35 AM determined she thought Glimepiride might be a blood pressure medication. She stated CMA's were alerted to new resident medications on report, by the nurses, or when they showed up on the MAR. She did not talk to the nurse about the Glimepiride when the resident started taking it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165587	A. Building B. Wing	07/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northbrook Healthcare and Rehabilitation Center	6420 Council Street NE Cedar Rapids, IA 52402

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with Staff E, Registered Nurse, on 7/20/24 at 10:47 AM revealed she worked at the facility for 4 years. She indicated the diagnoses for medications were located in the electronic health record and the doctors and/or nurse practitioners signed medication orders weekly when they rounded. She stated before the error with Resident #2 there was not a method in place for double checking orders. Staff B, Licensed Practical Nurse, stated on 7/20/24 at 10:55 AM she did not know of any audits for medication errors, other than the people who are passing them checking to make sure the medication and the MAR matched. She said checking medications against orders and diagnoses did not happen often. An interview with agency Staff F, CNA/CMA, on 7/20/24 at 11:09 AM determined she was not aware of any medication concerns, there was no part of her CMA role that required her to check resident diagnoses against medications, and she did not know about any medication audits that might have taken place. During an interview with the Administrator on 7/19/24 at 4:02 PM she confirmed additional interventions with the pharmacy and providers to prevent future incidents had not been put in place according to their initial plan of correction. She indicated staff would benefit from a skills fair and additional internal auditing, and that staff education already provided needed additional documentation and follow up. On 7/20/24 at 3:17 PM the DON stated she considered this an unfortunate incident. The facility did not have a policy for medication errors, just a procedure which was not in writing. She expected if there was an error, the CMA would tell the charge nurse. The charge nurse would assess the resident for side effects, call 911 if needed, notify the family and the provider, complete risk management for root cause, and notify her. The DON confirmed most medications were administered by CMAs and not the nurses. The DON, nurses, pharmacy consultants, and providers were responsible for comparing orders to diagnoses. An undated policy titled Medication Administration Policy documented the facility would provide pharmaceutical services, including procedures to assure the accurate acquiring, receiving, dispensing, and administering of all medications, to meet the needs of each resident.