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	08/22/2024

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 48452 Based on record review, staff interviews, and policy review the facility failed to complete a quarterly assessment in a timely manner for 1 of 3 residents reviewed (Resident #2). The facility reported a census of 74 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. Section GG documented the resident used a walker or wheelchair for mobility and required set up or clean up assistance with sit to stand, chair to bed/bed to chair transfers, and toilet transfers. The electronic health record (EHR) for Resident #2 documented MDS assessments completed for discharge with anticipated return on 7/10/24 and entry back to the facility 7/11/24. The EHR showed a quarterly assessment due date of 7/26/24 with a complete by date of 8/9/24. At the time of this review that assessment due date was highlighted red and indicated it was 9 days overdue. An interview with the Director of Nursing (DON) on 8/18/24 at 1:43 PM determined MDS assessments should be completed quarterly, annually, and with significant resident changes. She was not aware of a late MDS and indicated she would need to look into it. Further review of the EHR on 8/21/24 at 2:56 PM indicated the MDS assessment was completed on 8/18/24 at 2:50 PM, documented in a Progress Note. An email from the Administrator, dated 8/17/24 at 2:36 PM, documented the facility did not have a written policy regarding resident assessments and care planning.

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	08/22/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48452 Based on observation, record review, resident interviews, staff interviews, and policy review the facility failed to follow a resident's Care Plan for transfers and to assess a resident immediately after a fall for 1 of 3 residents reviewed (Resident #6). The resident required a mechanical lift with the assistance of 2 staff for transfers. The facility failed to provide assistance of 2 while the resident was transferred in the shower room which resulted in the resident sliding out of the mechanical lift sling. The facility further failed to conduct an assessment of the resident prior to getting her up from the shower room floor. The facility reported a census of 74 residents. Findings include: The Minimum Data Set (MDS) for Resident #6 dated 5/23/24 documented a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated intact cognition. Diagnoses included other acute paralytic poliomyelitis (polio, disease of motor neurons of the spinal cord and brain), repeated falls, and fracture (vertebra). The MDS documented the resident used a wheelchair for mobility and required substantial/maximal assistance for showering and bathing. The resident was dependent on staff for all transfers. Resident #6's Care Plan, with a focus area for ADL self-care performance deficits revised 9/20/23, included bathing and transfer interventions revised 4/12/24. At that time the resident required extensive assistance by 1 staff with showering twice a week and as needed, and transfer assistance of 2 staff with a Sara lift (standing mechanical lift) to shower. On 8/12/24 the bathing section was updated to change the Sara lift to a Hoyer lift (full body mechanical lift), and the resident remained an assist of 2. A Late Entry Progress Note titled Nursing Progress Note, dated 8/10/2024 at 15:02, was entered in Resident #6's electronic health record (EHR) on 8/11/24 at 16:06. It documented the following encounter with the resident and Staff C, Certified Nurses Aide, (CNA): This nurse (Staff B, Registered Nurse (RN)) was sitting in the nurses station when notified by (Staff C) as she was wheeling patient past the nurses station back to her room that the resident did not fall in the shower. (Staff C) stated that (the resident) was supported as her legs were already giving out and it was not possible to lift her even further, she was transferred to her wheelchair using the gait belt. This nurse followed them to her room and did vital signs and an assessment. 120/70, 80, 14, 97.8, 96 RA. Patient denied having pain. Patient stated that she did not fall and that she was ok. A Progress Note dated 8/10/24 at 17:07 titled Nursing Progress Note indicated Staff B was called into the resident's room for two skin tears on her right forearm that needed dressing. One measured 5 mm by 5 mm and the other 20 mm by 10 mm. The note indicated the provider was faxed for an order. The cause of the skin tears was not documented. (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	08/22/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	A form titled Skin Condition Record, initiated 8/10/24, documented the skin tears as they measured in the Progress Note. It indicated the plan of care was updated. The physician and family were notified on 8/11/24. The resident was not experiencing pain related to the wounds. The cause of the skin tears was not documented. The Progress Notes and the EHR lacked an incident report, full resident assessment, family notification, provider notification, or Director of Nursing (DON) and/or Administrator communication completed on 8/10/24 regarding the resident's assisted fall in the shower room. A Progress Note dated 8/11/24 at 9:30 AM documented the resident reported to Staff E, RN that she was in the Sara lift the day before during the 2 PM to 10 PM shift for a shower and fell . The note documented dry dressings on the resident's arm and complaints of increased back and right foot pain without bruising or deformity. Vitals were taken, feet were floated, and pain cream was applied to the resident's back. A Progress Note dated 8/11/24 at 11:36 noted the resident's daughter was in the facility and was aware of the situation. A Progress Note dated 8/11/24 at 12:04 titled Communication - with Physician reported the resident fell out of the Sara lift on 8/10/24 while being transferred for a shower. The resident complained of increased right shoulder/right upper arm and back pain. The note indicated the resident's daughter requested x-rays of the right upper arm, right shoulder, and back. A Progress Note dated 8/11/24 at 15:12 titled Nursing Progress Note reflected an order from the resident's doctor for a one time dose of 800 milligrams oral ibuprofen. A note dated 8/12/2024 at 08:04 titled Nursing Progress Note revealed the resident complained of pain in her right arm, right hip, across chest, and anterior shoulder, especially with ROM (range of motion). She rated her pain at 7/10 and requested to stay in bed that morning. Documentation of the facility investigation dated 8/12/24 at 8:30 AM included an interview with Resident #6 who confirmed Staff C did not have a second helper during the transfer and indicated her arm hurt when she was transferred from the floor. The resident interview documented the nurse did not complete an assessment and it was a long time before she came to bandage her arm. At least an hour. At 10:00 AM, the DON and Administrator interviewed Staff C who revealed she did not have a second person during the transfer but knew she should have. After Staff C lowered the resident to the floor, she got Staff I, Agency CNA to help her. Staff C stated she couldn't find the nurse and that was why she didn't have her do the assessment. The investigation included a statement from Staff C: Resident was given a shower alone and was lifted on the Sara lift and was transferred on her own to her wheelchair. The resident's legs gave out and while it gave out, I supported her shoulder and back while gently lowering her to the floor. I called another CNA and he put a gait belt to help her lift and transfer to the wheelchair. I reported to the nurse what had happened and insisted on giving her an assessment and check her vitals. (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	08/22/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	Investigation documentation also included a statement from Staff I that he went to answer the call light while Resident #6's shower was taking place at around 3:00 PM. When he left that resident's room, Staff C informed him Resident #6 was on the floor. He asked if the nurse knew because he was not going to get her up. Staff C told him no and they could get her up. They lifted her using the gait belt. He saw a skin tear on the resident's right arm. He reported they took her to the nurses station and there was not a nurse there, so they took the resident to her room. 15 minutes later he saw the nurse was assessing her. He reported never transferring a resident alone if they were an EZ Stand (another name for a Sara lift or standing mechanical lift). A Progress Note dated 8/12/2024 at 08:55 AM titled Nursing Progress Note revealed an order was received for spinal, lumbar thoracic, 2 view right hip et 2 view right shoulder X-ray. Order noted in queue. (X-ray company) notified. The resident's power of attorney was notified at 09:04. A note titled Nursing Progress Note on 8/12/24 at 12:48 revealed the X-ray results were negative for fracture and faxed to the resident's provider. A Progress Note dated 8/12/2024 at 13:58 titled Nursing Progress Note indicated she continued to have widespread pain, especially with movement and repositioning. She had not been out of bed during the shift due to her pain. A document from the resident's provider titled ICF Progress Note with an 8/12/24 date of service documented the resident's legs gave out on her when staff transferred her. The resident had increased pain and discomfort. The provider noted a history of chronic pain due to a T12 compression fracture and chronic pain medication, scheduled and as needed. There were no acute findings on the X-rays. The provider added a pain patch to her regimen that would be replaced weekly and ice as needed. A Progress Note dated 8/13/2024 at 12:06 titled Nursing Progress for a follow up on a staff assisted incident revealed the resident continued to complain of right shoulder and right anterior chest wall discomfort. She was able to move her right upper extremities with some discomfort but stated that it felt better. On 8/16/24 at 1:24 PM, during an observation and interview with Resident #6, she stated that on Saturday (8/10/24) she changed from a Sara lift to a Hoyer lift after her legs gave out on her. She pointed to her left arm and said she hurt her right shoulder, arm, knee, and hip and had been spending more time resting. She reported no breaks but that she had pain, and it felt better lying down. She thought the knee and hip pain was from hitting the floor and the arm and shoulder pain from holding on to the stand. Resident #6 was not exhibiting any signs or symptoms of pain at the time of the observation, no grimacing, jerky movements, or holding on to her arm or shoulder. She believed the facility was managing her pain. (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	08/22/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	The following day, 8/17/24 at 12:26 PM, the resident's daughter and the resident offered additional information. Observed skin tears bandaged near the resident's right wrist. Her daughter stated the resident's skin is very fragile and this happened often. Resident #6 stated it felt like a long time to get them wrapped by the nurse the day of the fall, and the CNA had to ask multiple times. The resident confirmed she refused imaging beyond the x-ray and added she was not interested in therapy. Both the resident and daughter endorsed a long history of chronic pain and pain medication. The resident stated the patch the doctor prescribed was helping, and she had both scheduled and as needed pain medication. The resident's daughter mentioned an incident a couple of months prior where an agency CNA transferred the resident without checking her transfer status. They felt the facility handled that well and the resident felt safe. In the most recent incident on 8/10/24, they both mentioned that the lack of a thorough assessment and that the information was not passed between shifts was concerning. On 8/17/24 at 1:58 PM Staff F, Agency CNA, confirmed he worked with Resident #6 and she used a Sara lift. He reported being trained that any time a resident went to the floor it was a fall, and a CNA might have to write a statement about what happened before the fall as part of the investigation. The CNA should make sure the resident was safe, and get a nurse to complete an assessment before a resident was moved. He reported staff on one shift were responsible for reporting resident changes, including falls, to the next shift. He stated he learned about this incident from the resident when he returned to work 2 days later, and she told him she fell out of the lift and hurt her arm and shoulder. During an interview with Staff E, RN on 8/17/24 at 2:16 PM she stated a fall was when a resident landed on the ground. Nurses were expected to complete incident reports immediately, document in the EHR, notify the physician and the family, and report to the next shift. They should notify the provider by phone if the resident was on a blood thinner or was injured and could make the notification by fax if there were no immediate concerns. She stated nothing was reported to her when she arrived the day after Resident #6's fall, and there was no incident report, assessment note, or documentation in the EHR other than a record of 2 skin tears. She learned of the incident from the resident who told her an assessment hadn't been done. Staff E added that this resident had also been transferred in June without a mechanical lift by an agency CNA who had not looked at the resident's transfer status before moving her. That CNA has not been back to the facility. At 2:32 PM on 8/17/24 Staff G, CNA, stated she was not there the day Resident #6 fell but the resident always used a Sara lift and was supposed to have two staff helping her. Staff H, CNA stated on 8/17/24 at 3:59 PM that staff got to know residents and their needs. She reported if a resident fell then CNAs should make sure they were okay and not move them until a nurse completed an assessment. She stated if they were safe she would look out the door for help. If no one was visible she would pull that call light to send a signal that she needed help. (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	08/22/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	During Staff C's initial interview on 8/18/24 at 8:14 AM she stated mechanical lift decisions and changes came from the doctor and the nurse. She confirmed there were no changes for Resident #6 the day she fell . Staff C reported she had fall training when she started and was paired up with another staff who trained her about expectations. She explained a fall happened when a resident landed on the floor. When asked about the incident on 8/10/24 with this resident, she stated she finished the resident's shower and began moving her to her wheelchair with the lift when the resident's legs gave out. She first stated the resident didn't fall on the floor because she supported the resident's back and arm. Staff C later stated the other CNA put a gait belt on the resident and they lifted her from the floor to the wheelchair. She was standing on the resident's right side and he was on the left side, and the resident's arms remained up. Staff C first said the resident didn't have any pain, then stated she complained that her arms were sore. Staff C first stated she had to insist the nurse do an assessment, then admitted to getting the resident up without getting the nurse first. She stated she did not notice skin tears during the shower, and did not notice them until the resident called her in before dinner. Staff C thought the shower was around 3:00 PM, vitals between 3:30 and 4:00 PM, and the wound dressing around 5:00. She didn't think the nurse completed a full body assessment if she missed the skin tears. On 8/18/24 at 1:43 PM the DON, when asked about the facility process when staff do not follow a resident's Care Plan, stated they investigated, determined what led to it, and provided education and/or initiated disciplinary action. She reported Staff C was not following the Care Plan by not having a second staff with her and the expectation was always for 2 staff. When asked about the interventions the facility put in place after this incident to keep residents safe during transfers, she stated the facility re-educated all CNAs regarding the facility's two person transfer requirement when using mechanical lifts and making sure a resident was assessed before they were moved. She provided documentation of that training as well as training for the nursing staff regarding completing full assessments prior to moving a resident after a fall. She provided the disciplinary action that included suspension of both the CNA and the nurse involved. The DON stated staff had access to the most updated transfer information on their tablets and/or nurses report sheets daily. When asked if this incident was preventable, the DON stated upon staff interviews they knew to use two people. She also felt staff had not communicated with her or the MDS coordinator to let them know the resident was getting weaker. That communication would have been helpful to prevent this incident. During an interview on 8/18/24 at 2:37 PM the Administrator stated she was not made aware of the resident's fall until the following day. The DON called and explained the incident stating the family and the nurse were upset. The nurse on duty did not complete an incident report because she was told it was not a fall. They initiated an investigation with in house interviews and the information they were getting was not consistent. She reported she can't honestly say what happened because of the inconsistencies. The Administrator, when asked about the resident's transfer status, did confirm that the resident should have been assisted with the transfer by 2 staff and the resident should have been assessed prior to being moved. At 10:23 AM on 8/19/24 Staff B, RN, confirmed she was the nurse on duty when Resident #6 had her fall and stated it was a very busy day. She reported Staff C wheeled the resident by the nurses station after her shower and told her the resident didn't fall. Staff B indicated she went to the resident's room and took her vitals, which were okay. She wasn't sure why the CNA said the resident didn't fall, and reported the resident had a smile on her face. Staff C again said the resident didn't fall. She said the resident appeared fine, and that was the last she knew until the DON called her. (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	08/22/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	Staff B stated everything surfaced the next day, and Staff C lied to the DON about what happened with the resident's transfer. Staff C reported there had been another CNA with her and that she had to ask 3 times for the nurse to do an assessment. Staff B also stated Staff E told her the next morning she should have filled out an incident report, and called the family and provider, but Staff B was confused because Staff C said the resident didn't fall. She stated she didn't know there was an issue to call about. She clarified Staff C told her they assisted the resident from the lift to the wheelchair, not from the floor to the wheelchair. Staff B then stated she panicked and called the DON. She confirmed she entered the incident report, and notified the POA and provider on 8/11/24 as late entries. Staff B reported that Staff C eventually admitted she was alone during the transfer, apologized for not telling the truth, and told her she did it because she didn't want to get into trouble. Staff B said she resigned when approached with a disciplinary report because of how accusing ' they ' were and because the report was the same as the CNA's even though Staff C lied. She said she couldn't work there like that and there were too many residents for one nurse to be responsible for anyway. On 8/21/24 at 4:07 PM, during an interview with Staff C, she verified she received fall training during her orientation and Resident #6 was an assist of two staff at the time of the fall. She acknowledged the facility requirement was for a 2 person transfer for mechanical lifts and that the resident was not assessed by a nurse prior to getting her up from the floor. She confirmed she chose to transfer the resident alone and stated she felt pressured to move the resident so she didn't get cold. She clarified the resident didn't say she was cold, she just knew it could happen. Staff C stated again that she was on the right side and Staff I was on the left side, and reported not being sure how the resident got the skin tears on her right arm. She avoided the question asking which one of them decided to get the resident up without being assessed. She was aware of the resident's prior incidents of weakness and back pain. Staff C believed this incident could have happened with two people because of that. She reported not knowing why the resident had arm and shoulder pain, and denied the resident reported pain to her at the time of the fall. She stated the resident was never left alone even when she looked for another CNA. She repeated she told the nurse as they walked by the nurses station that the resident needed to be assessed. She didn't know why Staff I said the nurse wasn't there. Staff C stated the resident told the nurse she didn't fall, and the nurse said it wasn't a fall. She denied the nurse's claim that she said the skin tears were there before the fall. At the end of the interview, when asked about staffing, the CNA stated there was a lot of work but they could usually get it done. At 5:02 PM Staff C shared that she wanted to add something about staffing. She stated staffing was actually a big concern of hers. She felt there were not enough staff who actually knew the residents that day, and felt like she had to do everything herself. She did not think 3 CNAs was enough for 70 residents when so many require 2 staff to transfer. In an email dated 8/17/24 at 2:36 PM the Administrator documented the facility did not have a policy or procedure related to resident transfers (technique, training, decision making, etc.). They also did not have a policy related to assessments. The facility's policy titled Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy, dated only as October, documented that all residents had the right to be free from abuse and neglect. Page 3 noted the facility would provide a supportive and safe environment for all residents to the extent possible through the deployment of trained and qualified staff to meet resident needs as identified in both the individual resident care plans and the facility assessment.