

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165587	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/14/2025
NAME OF PROVIDER OR SUPPLIER  Northbrook Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation, clinical record review, resident interviews, staff interviews, and policy review the facility failed to treat residents with dignity and respect, and to provide care in a dignified manner for 3 of 4 residents reviewed for dignity (Residents #58, #85, #93). Facility staff failed to maintain a resident's wheelchair in a clean and sanitary manner, staff used an expletive when describing a resident's behavior in front of others, and the facility posted signs in a resident's room regarding toileting without consulting them. The facility reported a census of 85 residents. Findings include:</p> <p>1. The Minimum Data Set (MDS) for Resident #85 dated 7/10/25 listed diagnoses of cancer, non-Alzheimer's dementia, hip fracture, and dependence on a wheelchair. His Brief Interview for Mental Status (BIMS) assessment score of 5/15 indicated severe cognitive impairment.</p> <p>The Care Plan (CP) for Resident #85 revised 10/23/24 indicated the resident had limited physical mobility and ambulated with a wheelchair in the hallway. The CP listed a goal to prevent complications related to immobility that included skin breakdown. An intervention initiated 11/7/23 revised on 5/22/25 directed staff to clean the wheelchair weekly.</p> <p>During an interview at 11:42 AM on 8/11/25 a resident representative expressed concerns about cleanliness. They reported the resident did receive a shower twice a week but their wheelchair was not cleaned regularly, and the cushion in the chair smelled of urine. The representative mentioned being embarrassed at a recent appointment because the smell was so bad and stated other members of the resident's family reported similar concerns. The representative stated they asked for the chair to be cleaned more than once.</p> <p>During on observation on 08/11/2025 at 2:49 PM the resident's wheelchair was next to his bed. There was a noticeable odor coming from the chair. When the cushion was lifted it exposed crumbs in all of the fasteners lining the sides of the chair below the arm rests.</p> <p>A follow up observation on 08/12/2025 at 1:42 PM revealed the wheelchair had not been cleaned</p> <p>On 08/13/2025 at 9:52 AM Resident #85 wheeled himself into his room from the hallway. An odor of urine was noticeable from his wheelchair as he pushed himself around the corner and adjusted himself in his seat. At 1:13 PM the resident reported they cleaned his wheelchair when they had time. Upon raising the cushion crumbs remained pressed against the fasteners and smears of an unknown substance were on the arm rests. There was a stain on the back of the cushion and a strong urine odor coming from it.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/14/2025 at 9:23 AM Staff I, Certified Nursing Assistant (CNA) confirmed she worked with Resident #85. She stated third shift had a checklist for wheelchair cleaning but any CNA could get crumbs off and bleach wipe a chair, at least that is what she would do. She stated she would inform the restorative staff or maintenance and try to figure out how to get the cushion clean.</p> <p>An interview with the Assistant Director of Nursing (ADON) on 8/14/2025 at 9:54 AM revealed she was aware wheelchairs were not being cleaned according to a schedule she set up 4 months ago. She stated third shift CNAs were supposed to follow a cleaning schedule she provided. They had not been doing it in spite of training, and the facility was planning to roll it out again in September. She stated if staff saw a dirty wheelchair or smelled an odor on one she expected them to clean it up regardless of the schedule.</p> <p>A blank document titled Nightly CNA duty list was provided by the ADON which verified the resident's wheelchair had not been cleaned that week.</p> <p>2. The MDS assessment tool, dated 6/5/25, listed diagnoses for Resident #93 which included non-Alzheimer's dementia, depression, and anxiety. The MDS stated the resident had physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) 1-3 days out of the 7 day review period. The MDS listed his Brief Interview for Mental Status(BIMS) score as 2 out of 15, indicating severely impaired cognition.</p> <p>The facility policy Promoting/Maintaining Resident Dignity, dated 3/27/25, stated the facility protected and promoted resident rights, treated each resident with respect and dignity, and cared for each resident in a manner that maintained or enhanced quality of life by recognizing each resident's individuality.</p> <p>Care Plan entries, dated 5/2/25, directed staff to give the resident reassurance as needed and visit with him about feelings/events that bothered him.</p> <p>On 8/11/25 at 11:35 a.m., Staff B Certified Nursing Assistant(CNA) walked by the nurses station and stated she attempted to assist Resident #93 but he slapped the s***(expletive) out of me. Staff B stated this while near the nurses station with residents in close proximity at the dining tables and other staff at the nurses station.</p> <p>On 8/13/25 at 4:38 p.m., the Director of Nursing(DON) stated it was not acceptable for staff to state something in public about a resident in front of others.</p> <p>On 8/13/25 at 5:05 p.m., the Administrator stated staff should treat residents with dignity and respect and not speak negatively about them in front of other residents.</p> <p>3. The MDS assessment for Resident #58, dated 7/11/25, identified the resident had diagnoses of heart failure, repeated falls and difficulty in walking. The MDS assessment revealed a BIMS score of 5 (indicative of severe cognitive impairment) and assessed the resident was dependent on staff for toileting and transfers.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Care Plan, last revised 8/12/25, revealed the resident required assistance by staff with a walker for toileting and transfers. The Care Plan identified the resident was a fall risk and included the following interventions: Sign placed in room to encourage call light use for help getting up (dated 8/5/25); and, sign placed on walker to ask for assistance before getting up (dated 8/9/25).</p> <p>On 8/12/2025 at 8:05 AM, during an interview, Resident #58 reported he did not like the signs posted in his room and walker to use the call light and ask for help. Resident #58 reported the signs were irritating and insulting to his intelligence. Resident #58 explained he had a couple falls back to back last week, one at night and one in the morning. After the falls, Resident #58 described staff as giving him heck and then putting the signs in his room without asking if it was okay. Resident #58 reported he had to go to the bathroom and used his call light prior to each of the falls. Resident #58 explained staff did not respond for about one hour, he got tired of waiting, got up and fell.</p> <p>Review of Progress Notes, titled Nurses Note Narrative, dated 8/5/25 at 5:58 AM and 8/5/25 at 4:05 PM, Resident #58 had falls in relation to trying to use the bathroom in his room. A Nurses Note Narrative, dated 8/9/25, included documentation the resident was found sitting on the floor in front of the toilet in his room. Resident #58 was noted to be continent and reported he lost his footing while entering the bathroom. The Progress Notes lacked documentation facility staff discussed changes to the care plan with either the resident or resident's representative to include the interventions of signs.</p> <p>On 8/13/2025 at 11:13 AM, Staff N, Certified Nurses Aide (CNA), reported Resident #58 did not like to wait when he needed to use the bathroom. When asked by the surveyor if Resident #58 had complained about the signs in his room, Staff N reported Resident #58 did say something the other day after falling about the signs. Staff N reported Resident #58 said that if he had to go, he was going to get up and go no matter what the signs told him.</p> <p>Facility staff failed to consider the dignity and response of the resident when posting signs in the resident room.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on clinical record review, staff interview and policy review the facility failed to complete an assessment for 1 of 4 residents (Resident #96) reviewed for hospitalizations. The facility reported a census of 85 residents. Findings include: Progress Notes written on 6/3/25 at 4:28 PM document Resident #96 readmitted to the facility following cholecystitis (inflammation of the gallbladder), sepsis (sepsis happens when an infection you already have triggers a chain reaction throughout the body. It is a life threatening, medical emergency per the Center for Disease Control (CDC)), and septic shock (a severe form of sepsis characterized by dangerously low blood pressure and abnormalities in cellular and metabolic function). The clinical record lacked a physical assessment or vital signs on 6/3 and 6/4. The pre-dialysis assessment completed on 6/5 included vitals of Temperature 97.2 Fahrenheit (F), Pulse 88, Respirations 16, Blood Pressure (BP) 96/56 and oxygen saturation (O2 Sat) of 88%. The post-dialysis assessment completed on 6/5 included vitals of Temperature 98.7 F, Pulse 80, Respirations 18, BP 124/80 and O2 Sat of 98%. The clinical record lacked a physical assessment on 6/5. The clinical record lacked a physical assessment or vital signs on 6/6. The pre and post dialysis assessments on 6/7 lacked vital signs. The clinical record did include a temperature of 97.7 F. The clinical record lacked vital signs on 6/8 and 6/9. The clinical record lacked a physical assessment on 6/7 and 6/8. Progress Note written on 6/8/25 at 1:30 PM documented the resident had picked a scab and staff were unable to stop the bleeding. The nurse completed the dressing change to the resident's legs that started bleeding and running down her leg. The resident was sent to the Emergency Department (ED). The clinical record lacked documentation of the resident returning from the ED, vitals or physical assessment upon return. Progress Note written on 6/9/25 at 11:36 AM documented the resident had copious amounts of drainage from bilateral leg wounds. She had poor circulation to all extremities, fingers and toes purple and cold and difficulty in getting an O2 sat reading. Progress Note written on 6/9/25 at 3:39 PM documented the resident was to be admitted to the hospital per her cardiologist. There were no vital signs documented on 6/9. Progress Note written on 6/10/25 at 12:20 AM documented the resident was admitted to the hospital with diagnosis including sepsis. During an interview on 8/13/2025 at 12:54 PM, the Director of Nursing (DON) explained the resident went out and came back in less than 24 hours so didn't require a full admission assessment on 8/13/25. The DON was unable to locate vital signs or an assessment. At 1:00 PM, the DON reported she would have to ask the Assistant Director of Nursing (ADON) as she was able to locate information in the electronic health record better than I can. On 8/14/25 at 9:57 AM the DON and ADON were unable to provide and additional documentation of vital signs or physical assessments. The undated facility policy titled Change in Condition Protocol directs staff to evaluate the resident's condition when a change from baseline is observed, complete a full assessment and document in Point Click Care (PCC), and every shift is required to perform and document vitals and a focused assessment. The policy further directs staff that there are no exceptions to this requirement.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, clinical record review, and staff interviews, the facility failed to utilize foot pedals during wheelchair transport in order to ensure safety and failed to ensure good working order of a walker to prevent falls for 3 of 5 residents reviewed for accidents (Residents #12, #49, and #101). The facility reported a census of 85 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 6/18/25, listed diagnoses for Resident #12 which included non-Alzheimer's dementia, anxiety disorder, and cancer. The MDS stated the resident was dependent on staff to propel her wheelchair and listed her Brief Interview for Mental Status (BIMS) score as 12 out of 15, indicating moderately impaired cognition.</p> <p>On 8/11/25 at approximately 11:00 a.m., Staff A Hospice Tech pushed Resident #12 in her wheelchair from the nursing station to her room, a distance of approximately 50 feet. The resident's feet were not placed on foot pedals and the bottoms of her feet lightly touched the ground while Staff A pushed her.</p> <p>On 8/13/25 at 4:38 p.m., the Director of Nursing (DON) stated foot pedals should be used if staff pushed residents in their wheelchairs.</p> <p>On 8/14/25 at 11:15 a.m., the Administrator stated she did not have a policy related to foot pedals.</p> <p>2. The MDS for Resident #49 dated 8/7/25 revealed diagnoses of fracture, muscle weakness, and abnormal posture. The BIMS documented a score of 14/15 which indicated intact cognition. Section GG indicated the resident experienced functional limitation in range of motion in both lower extremities.</p> <p>The Care Plan (CP) for the resident dated 5/6/25 indicated they had an activities of daily living (ADL) self care performance deficits and were at risk for falls. Resident #49 needed assistance with maintaining a safe environment.</p> <p>During a dining room observation on 8/13/2025 at 8:54 AM Staff G, Certified Nurses Aide (CNA) pushed Resident #49 in his wheelchair from the dining room down the A hallway to his room without the use of foot pedals for safety. The resident was able to hold his feet up past the nurses station and 3 doors, then his feet started to drop towards the floor as they passed 3 more doors to get to his room.</p> <p>On 8/13/2025 at 9:04 AM the Administrator stopped in the hall while the surveyor was waiting to speak with Staff G. She stated she saw Staff G push the resident in the hallway without pedals and had already provided education to the CNA that residents should not be transported in wheelchairs without foot pedals.</p> <p>On 8/13/2025 at 9:09 AM an interview with the resident revealed that the pedals got in the way at the table in the dining room so staff often just left his pedals in his room. An observation during the interview determined his pedals were on his floor under his sink and there was not a bag for pedals on the back of his wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Assistant Director of Nursing (ADON) on 8/14/2025 at 9:54 AM she stated the facility did a wheelchair audit recently because it was a common thing for them to catch missing foot pedals and she thought residents needed bags for them on the back of their chairs.</p> <p>3. The MDS for Resident #101 dated 5/27/25 (3 days after his fall) revealed diagnoses of cancer, hip fracture and other fracture (rib), and malnutrition. The BIMS documented a score of 15/15 which indicated intact cognition. Section GG indicated the resident experienced functional limitation in range of motion in one lower extremity and used a walker with supervision or touch assistance.</p> <p>The baseline Care Plan (CP) for the resident dated 5/20/25 indicated the resident needed physical, occupational, and speech therapies. It documented a history of falls and fall related injuries of right femur fracture and rib fractures. It listed the resident used a walker and wheelchair.</p> <p>A document titled Physical Therapy Treatment Encounter Notes, date of service 5/26/25, documented Resident #101 was weight bearing as tolerated and contact guard staff assist with a four wheel walker for toilet transfers during the session.</p> <p>A Progress Note titled admission Follow-up Note dated 5/25/25 at 12:14 AM documented the resident was found on the floor next to his bed with his back against the bed and his legs out in front of him. He stated he was going from the chair to the bed when his walker collapsed and he fell. The resident told staff he had permission from therapy to transfer in his room. The note further documented staff obtained a different walker for the resident as he was correct in stating the walker collapsed. The writer noted the walker was in poor condition and had screws missing that would keep the walker working properly. The Assistant Director of Nursing (ADON) was notified.</p> <p>On 8/14/2025 at 8:36 AM the Director of Nursing (DON) reported the Assistant Director of Nursing (ADON) was responsible for monitoring cleaning of equipment and ensuring staff monitored it for safety.</p> <p>During an interview with the ADON on 8/14/2025 at 9:54 AM she reported when she thought about the walker, she recalled one of the sides didn't have something right about it and it was discussed in a morning meeting. She stated the restorative aide would have been responsible for checking the walker and it should have been repaired or out of service if not safe. She said she would need to continue to work with the new restorative aide to monitor things like that.</p> <p>On 8/14/2025 at 10:21 AM the Administrator stated she thought the documentation had been over-exaggerated. She recalled the walker was disposed of and discussed that morning in a quality assurance meeting. The restorative aide participated and staff were told to double and triple check equipment for safety after the incident. She also asked maintenance and therapy to look into it.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, resident interviews, staff interviews, and policy review the facility failed to answer call lights within 15 minutes to meet resident needs for 7 of 9 residents reviewed (Residents #13, #28, #53, #55, #58, #60, #81). The facility reported a census of 85 residents. Findings include:</p> <p>1. The Minimum Data Set (MDS) for Resident #53 dated 7/28/25 listed diagnoses of hemiplegia and hemiparesis (weakness/loss of movement on one side of the body), urinary tract infection in the past 30 days, and cerebral infarction (stroke). The Brief Interview for Mental Status (BIMS) indicated intact cognition with a score of 13/15. Section GG indicated the resident required assistance with self care due to functional limitations that interfered with daily function on one side of his upper body and both sides of his lower body.</p> <p>The Care Plan (CP) for Resident #53 with an admission date of 7/22/25 documented activities of daily living self care deficits and directed staff to encourage the resident to use the bell to call for assistance. A section that documented a risk for falls directed staff to ensure the call light was in reach and to encourage the resident to use it. The resident needed prompt response to all requests for assistance.</p> <p>During an interview on 8/11/2025 at 8:54 AM the resident reported the some days call lights were longer than they should be. He thought they should be answered in 10-15 minutes and stated he knew others needed help too.</p> <p>During an observation on 8/11/25 the surveyor noticed the call light on at 12:46 PM for the resident's room. At 12:50 a staff member walked by without answering the light. At 12:53 PM the surveyor stood by the resident's room. Resident #53's roommate (Resident #55, MDS dated [DATE] BIMS 5/15 which indicated severe cognitive impairment) was sitting in bed with a tray in front of him on the bedside table. He waved the surveyor in. He stated his call light was on because he needed his table higher so he could eat better. At 12:59 PM 2 staff walked by headed toward the dining room and offices at the end of the hall. Neither staff member addressed the light. At 1:02 PM the surveyor observed staff at the medication cart in view of the call light. She did not respond. At 1:03 PM the Director of Nursing (DON) came out of her office directly across the hall and did not address the light. At 1:03 PM the same 2 staff who walked by at 12:59 returned to the hallway. Neither addressed the light. At 1:04 PM a nurse walked by and did not address the light. At 1:04 PM a dietary staff member walked by and did not address the light. At 1:05 PM a CNA answered the light and assisted the resident with adjusting the table. She left without asking if the resident needed his food warmed.</p> <p>During a follow up interview with Resident #53 and his roommate Resident #55, Resident #55 was unable to answer call light questions. When asked if there were other days or specific times call lights were over 15 minutes, Resident #53 stated his roommate couldn't remember but he could. He stated call lights were often as long as 30 minutes. He knew because he watched a lot of television shows that were 30 and 60 minutes long.</p> <p>On 8/14/2025 at 9:23 AM Staff I, Certified Nurses Aide (CNA) stated all staff are responsible for answering call lights.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/14/2025 at 9:33 AM Staff H, Registered Nurse (RN) stated answering call lights was a collaborative effort.</p> <p>On 8/14/2025 at 9:54 AM the Assistant Director of Nursing stated all staff were expected to answer call lights.</p> <p>The facility policy Call Lights: Accessibility and Timely Response, dated 3/27/25, directed staff to respond to call lights and if they could not meet the resident's request, to remain with them until help arrived.</p> <p>2. The MDS assessment tool, dated 7/7/25, listed diagnoses for Resident #13 which included diabetes, depression, and respiratory failure. The MDS stated the resident required substantial/maximal assistance for toilet transfers and listed his BIMS score as 15 out of 15, indicating intact cognition.</p> <p>On 8/11/25 at 11:00 a.m., Resident #13 stated he did not get care in a timely manner. He stated he needed to use the bathroom and sat helpless three feet from the toilet waiting for staff for 20 to 30 minutes. He stated he had an incontinence accident that was preventable if staff had been there in time.</p> <p>3. The MDS assessment tool, dated 8/4/25, listed diagnoses for Resident #28 which included muscle weakness, lack of coordination , and abnormal posture. The MDS stated the resident was dependent on staff for toilet transfers and listed the resident's BIMS score as 13 out of 15, indicating intact cognition.</p> <p>On 8/11/25 at approximately 2:00 p.m., Resident #28's spouse stated the resident had to go to the bathroom and staff said they would be right back but never returned. He stated they had to wait until shift change three hours later and by that time the resident had an incontinence accident. Resident #28 stated this made her feel terrible.</p> <p>4. The MDS assessment tool, listed diagnoses for Resident #60 which included weakness, lack of coordination, and diabetes, and listed his BIMS score as 11 out of 15, indicating moderately impaired cognition.</p> <p>On 8/11/25 at 4:16 p.m., via phone, Resident #60's spouse stated on 8/1/25, the resident reported to her that staff took too long to assist him to the bathroom so he had an incontinence accident. The resident stated staff kept coming in and stating they would be back but not return for an hour.</p> <p>An 8/1/25 Care Plan entry stated the resident required the assistance of two staff for toileting.</p> <p>On 8/13/25 at 11:22 a.m., via phone, Staff O Certified Nursing Assistant(CNA) stated she took care of Resident #60 on 8/1/25. She stated that day was very chaotic and there were many residents which required the assistance of two staff. She stated there were not enough staff to answer call lights in a timely manner and there was never enough staff for them to take care of everyone.</p> <p>5. The MDS assessment tool, dated 7/17/25, listed diagnoses for Resident #81 which included anxiety, depression, and weakness and stated the resident required substantial/maximal assistance for toileting hygiene. The MDS listed the resident's BIMS score is 14 out of 15, indicating intact cognition.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/12/25 at 9:25 a.m., Resident #81 stated that she was supposed to have help to go to the bathroom but because she had to wait an hour, she just went by herself.</p> <p>On 8/13/25 at 4:38 p.m., the Director of Nursing (DON) stated she expected staff to answer call lights within 10 minutes or at least enter the room to touch base with the resident and tell them they would be back. She stated they had a lot of residents which required the assistance of two staff so it could take a minute.</p> <p>On 8/13/25 at 5:05 p.m., the Administrator stated staff should answer call lights in a timely manner and they added more staff.</p> <p>6. The MDS assessment for Resident #58, dated 7/11/25, identified the resident had diagnoses of heart failure, repeated falls and difficulty in walking. The MDS assessment revealed a BIMS score of 5 (indicative of severe cognitive impairment) and assessed the resident was dependent on staff for toileting, lower body dressing, mobility and transfers.</p> <p>The Care Plan, last revised 8/12/25, revealed Resident #58 required assistance by staff with a walker for toileting, ambulation, and transfers. The resident required assistance of staff for dressing and personal hygiene.</p> <p>On 8/12/2025 at 8:05 AM, during an interview, Resident #58 reported he had to wait to get up for up to hour in the mornings, because he was waiting on help from staff. Resident #58 reported it (waiting to get up in the morning) happened frequently; he explained waiting to get up happened a couple times a week. Resident #58 reported going to the bathroom was the main issue. The resident reported he had a couple falls back to back last week, one at night and one in the morning. Resident #58 reported he had to go to the bathroom and used his call light prior to each of the falls. Resident #58 explained staff did not respond for about one hour, he got tired of waiting, got up and fell.</p> <p>Review of Progress Notes, titled Nurses Note Narrative, dated 8/5/25 at 5:58 AM and 8/5/25 at 4:05 PM, Resident #58 had falls in relation to trying to use the bathroom in his room. A Nurses Note Narrative, dated 8/9/25, included documentation the resident was found sitting on the floor in front of the toilet in his room. Resident #58 was noted to be continent and reported he lost his footing while entering the bathroom.</p> <p>On 8/13/25 at 11:05 AM, Staff B, CNA, explained the morning time was the busiest time at the nursing home. Staff B reported she had one other CNA working the hall she was on. Staff B reported there were a few times residents had to wait longer than 30 minutes for their call light to be answered.</p> <p>On 8/13/2025 at 11:13 AM, Staff N, CNA, reported Resident #58 did not like to wait when he needed to use the bathroom. Staff N reported the residents usually did not have to wait longer than minutes. Staff N reported the morning time was busiest with trying to get resident's up for the day.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165587	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/14/2025
NAME OF PROVIDER OR SUPPLIER  Northbrook Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, interviews, and policy review the facility failed to maintain a safe, functional, sanitary, and comfortable environment for residents. The facility failed to adequately clean toilets and keep them in good repair, ensure beds were made in a timely manner, and to repair damaged or missing window screens. The facility reported a census of 85 residents. Findings include:</p> <p>1. The Minimum Data Set (MDS) for Resident #85 dated 7/10/25 listed diagnoses of cancer, non-Alzheimer's dementia, hip fracture, and dependence on a wheelchair. His Brief Interview for Mental Status (BIMS) assessment score of 5/15 indicated severe cognitive impairment.</p> <p>The Care Plan (CP) for Resident #85 revised 10/23/24 indicated the resident had self care deficits and required the assistance of 1 staff with toileting before and after meals. The care plan documented a risk for falls, with interventions that included therapy evaluation 7/11/25, a toileting program at 7:00 am as of 7/23/25, non-slip footwear, and staying with the resident when using the toilet.</p> <p>During an interview at 11:42 AM on 8/11/25 a resident representative expressed concerns about wheelchair, bathroom, and room cleanliness. They reported the resident's wheelchair was not cleaned regularly and the cushion in the chair smelled of urine. The representative mentioned being embarrassed at a recent appointment because the smell was so bad and stated other members of the resident's family reported similar concerns. They further stated the toilet had been broken and overflowing 'forever' and it was always dirty in there.</p> <p>On 8/11/2025 at 2:49 PM the resident's toilet was running and the floor was damp.</p> <p>On 8/12/2025 at 1:42 PM the resident's bathroom floor remained wet and the toilet was running. Urine odor in bathroom and into room.</p> <p>On 8/13/2025 at 9:57 AM the resident's toilet was running, there was a strong odor of urine. The floor was wet to the corners, about a foot from the base, and about 9 - 12 inches in front of the toilet.</p> <p>On 8/13/2025 at 10:08 AM Staff Q, Housekeeping stated sometimes the residents using that bathroom had a lot of accidents and could use a cleaning twice a day. She indicated in a binder on the cart that the bathroom was scheduled for cleaning on Tuesday, Thursday, and Saturday. She stated the aides were supposed to help monitor and she had not been told there was an odor.</p> <p>During an interview on 8/14/2025 at 9:41 AM Staff J, Maintenance Director stated no one reported an issue with the toilet in the resident's room and should have told him or filled out a form in the maintenance book at the nurses stations. Maintenance documentation from May through August 2025 provided by the facility confirmed there was not a report for this room.</p> <p>An interview with the Administrator on 8/14/2025 at 10:21 AM determined she expected staff to use the maintenance book, verbal communication, or department group chats to get repairs made for safety. The running toilet had not been reported to her. She expected staff to make sure wheelchairs and bathrooms were clean, and equipment in working order.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Northbrook Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  6420 Council Street NE Cedar Rapids, IA 52402	
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. On 8/11/25 at 2:49 p.m. the bed in room [ROOM NUMBER] was not made and had a bare mattress.</p> <p>On 8/12/25 at 8:28 a.m., the bed in room [ROOM NUMBER] was only made with sheets but no blanket or bedspread.</p> <p>On 8/12/25 at 1:09 p.m., the bed in room [ROOM NUMBER] remained not fully made.</p> <p>3. On 8/13/25 at 9:05 a.m., the bathroom toilet in room [ROOM NUMBER] had black splatters inside the toilet and on the inside of the toilet riser. A graduate sat atop the toilet tank and contained a yellow liquid and the top of the tank had yellow splatters.</p> <p>On 8/13/25 at 2:23 p.m., the bathroom in room [ROOM NUMBER] remained unchanged.</p> <p>4. The MDS assessment for Resident #17, dated 5/22/25, identified the resident had a BIMS score of 14 out of 15 (indicative of a mild cognitive impairment).</p> <p>On 8/11/25 at 10:43 AM, Resident #17 reported concerns with a broken window screen in her room. She explained the screen had been broken all summer and the other 2 screens were missing. Resident #17 reported housekeeping had broken the window screen when they were cleaning it in either June or July 2025.</p> <p>5. The MDS assessment for Resident #7, dated 6/5/25, identified the resident had a BIMS score of 13 out of 15 (indicative of a mild cognitive impairment).</p> <p>On 8/11/2025 at 1:48 PM, Resident #7 reported the following concerns:</p> <p>a. Two different wall outlets were loose and her plug for her phone and Continuous Positive Airway Pressure (CPAP- a medical device used to treat sleep apnea or absence of breath when sleeping) machine were half-hanging out of the wall. Resident #7 reported she told the Maintenance Director about the concern in May of 2025, but nothing was done. She reported the Maintenance Director quit working at the facility a couple weeks ago. Observation of the two wall outlets revealed a plug-in for the phone and CPAP both hanging loosely from the outlet. Attempts to re-plug the phone and CPAP machine resulted in both plugs still hanging half-way out of the outlet.</p> <p>b. Resident #7 complained to staff that for 3 days in a row, there was BM (feces) on inside edge and top end of the toilet seat where the resident's upper thigh and leg would touch the seat. Resident #7 reported that the BM was still present on the seat as of today (8/11/25). Resident #7 reported the BM was from an episode of diarrhea her roommate had. Observation of the toilet seat revealed a dark brown, dried substance located on the inner left side of the seat and top end of the seat where the resident's back of their leg would touch.</p> <p>On 8/12/2025 at 12:13 PM, Staff Q, Housekeeping, reported she cleaned residents room daily and some rooms 2 times per day if requested. Staff Q reported when she cleaned the residents rooms she cleaned off counters, tray tables, dressers, toilet, handrails, sink and swept and mopped the floor.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Northbrook Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  6420 Council Street NE Cedar Rapids, IA 52402	
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/14/2025 at 8:06 AM, during an interview with Staff Q, Housekeeping, when asked if she had received any complaints from residents about their bathrooms not getting cleaned, she responded, It's on my weekend. I have the whole nursing home. Staff Q explained the she was the only housekeeper for the facility every other weekend. Staff Q reported the residents used to having their bathrooms cleaned by a certain time in the morning, but it might be afternoon before she got to them. Staff Q reported she had heard residents complain of not getting their bathrooms cleaned. Staff Q reported being off this last weekend and had not received a complaint about the bathroom from Resident #7. Staff Q reported facility staff had been in the process of cleaning and replacing screens for months. Staff Q was aware there were missing and bent window screens. Staff Q reported Resident #17 was correct that housekeeping staff were cleaning the screens and her window screen got bent by housekeeping.</p> <p>On 8/14/2025 at 8:12 AM, Staff R, housekeeping, reported she had heard complaints from residents about their toilets not getting cleaned. Staff R reported she cleaned Resident #7's toilet on Monday and the resident did not complain to her about staff not cleaning it for three days.</p> <p>On 8/14/25 at approximately 9:00 AM, the Housekeeping Manager provided an audit of window screens and window cleaning and replacement. Housekeeping staff documented they last cleaned Resident #17's windows and screens on 6/23/25.</p> <p>On 8/14/25 at 11:00 AM, during an interview, the Administrator reported they had been working on a facility wide project to replace window screens for the last several months. The Administrator reported being unaware of outlet issue in Resident #7's room. The Administrator contacted maintenance to repair the outlets immediately.</p> <p>Review of the undated facility policy, titled Housekeeping Daily Tasks, revealed directions to housekeeping staff to clean residents toilets daily.</p>		