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	10/21/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review, and facility policy review, the facility failed to respond in a respectful manner to a resident (Resident #7) who requested help to find a bathroom for 1 of 3 residents reviewed for dignity. The facility also failed to protect residents' right to privacy when electronic health information was left visible and unattended on a computer in 2 of the 4 hallways observed. The facility reported a census of 87 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 scored 13 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Resident #7's MDS had the following diagnoses listed, in part: Alzheimer's disease, Cerebral Vascular Accident (CVA or stroke), and cancer. The MDS identified that Resident #7 had a history of falling within the past month and required a partial to moderate amount of staff assistance for toilet transferring and toileting hygiene.Review of the Care Plan, initiated 9/18/25, revealed Resident #7 had a self-care deficit of Activities of Daily Living (ADL) related to impaired balance and limited mobility, and the intervention dated 9/18/25 revealed Resident #7 required one staff assistance for toileting. The Care Plan identified Resident #7 was at risk for falls related to confusion, deconditioning, gait/balance problems, incontinence, poor communication/comprehension, and unawareness of safety needs. Interventions directed, in part:a. Anticipate and meet the resident's needs. Date initiated 10/16/25.b.be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date initiated 10/16/25. During an observation on 10/20/25 at 12:08 PM Resident #7 self propelled wheelchair from her room into the hallway near Staff A, Registered Nurse (RN) who stood at the treatment cart. Resident #7 asked Staff A where the bathroom was located. Staff A responded that the bathroom was in her room and asked Resident #7 what she was doing out here (in the hallway). Staff A then asked an ancillary staff who passed by if there were any aides around here. The ancillary staff informed Staff A that she did not work at facility, Staff A stated I can't, I'm trying to get my treatments done (while referring to Resident #7). Staff A then walked away from Resident #7 and went into the dining room. During an observation on 10/20/25 at 12:16 PM, Resident #7 in her room unattended and in the process of self transferring from the wheelchair to the bed. Resident #7's pants and incontinence underwear were pulled up only part way, exposing Resident #7's upper buttocks. Resident #7's bathroom door was open and the light was on.During an interview on 10/21/25 at 3:20 PM, the Director of Nursing (DON) revealed the expectation of all staff was to treat residents with respect and dignity and to help residents when they asked for assistance. 2. During an observation on 10/20/25 at 9:35 AM, an unattended treatment cart was left unlocked in the middle of residential hallway B-wing. On top of the treatment cart was a laptop computer with a resident's picture and confidential health care information displayed on the screen. During an observation on 10/20/25 at 12:25 PM, Staff A, RN, walked away from the treatment cart, left in the middle of a residential hallway A-wing, to enter the dining room, out of sight from the treatment cart. On top of the treatment cart was a laptop computer with a resident's picture and confidential health care information displayed on the screen. Various residents and staff passed by the treatment cart on the way to the dining room for the noon meal. During an interview on 10/21/25 at 2:20 PM, Staff C, RN, stated that nurses were expected to lock computer screens when walking away to protect residents' privacy and confidentiality. During an interview on 10/21/25 at 3:00 PM, Staff D, RN, stated that nurses were expected to lock computer screens when walking away to protect residents' privacy and confidentiality. During an interview on 10/21/25 at 3:20 PM, the DON revealed the expectation of staff to protect residents' right to privacy by locking computer screens when not in use. Review of the facility policy, titled Resident Rights dated 8/10/03, revealed that the facility will protect and promote each residents' rights, including the right to a dignified existence, self-determination, and communication with and access to persons and services, both inside and outside the facility.