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	12/11/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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

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	12/11/2025

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 0760 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 observations, interviews, and record review, the facility failed to administer medications as ordered for 2 of 3 residents reviewed (Resident #1 and Resident #4) when Resident #1 received Resident #2's insulin injection and was transferred to the emergency room (ER) for close observation, and Resident #4 received Resident #8's morning medications and required monitoring of his blood pressure (BP) every shift for the following 72 hours. The facility reported a census of 77 residents. Findings include: 1.A Minimum Data Set (MDS) dated [DATE], documented diagnoses for Resident #1 included acute kidney failure, Type 2 diabetes and schizophrenia. A Brief Interview for Mental Status (BIMS) documented a score of 15 out of 15 which revealed intact cognition.A Medication Error Wrong Medication Incident Report dated 12/5/25 at 8:25 a.m., revealed Staff B, Licensed Practical Nurse (LPN) (Agency nurse) documented the following:While administering morning insulins, Resident #1 received the wrong insulin. (Staff A) Certified Nurse Aide (CNA) was questioned as to Resident #1's identity. When (Staff A) was questioned as to whether she was sure of (Resident #1's) identity, Staff A stated 'yes, she is the one with the red blanket right there.' When (Staff B) called the resident's name, the resident responded to the incorrect name with yes. While completing Vital Signs (VS) on the unit, (Staff B) noticed Resident #1 in her room with a different name tag on the door. Staff B notified administration immediately. Resident #1 stated she was feeling fine. There were no signs or symptoms (s/s) of hypoglycemia at this time as of yet. Blood Sugar (BS) check was 177. Administration notified immediately of medication error. Primary care physician notified of incident. Resident Blood Sugar taken (177). Order to send resident to the emergency room (ER) for evaluation and treatment. Resident was fed house supplement milk for protein and blood sugar support. 911 was called, and a report was given to the hospital. (Resident #1) was aware of the incident and new order to evaluate at the ER. (Resident #1) was sent to the hospital. Resident #1 was alert and oriented X 3 (oriented to person, place, and time), had no distress at the time of transfer. Recent Blood Sugar was 177, no acute distress noted. Sent to ER for observation due to risk. An ED (Emergency Department) Provider Notes dated 12/5/25, documented the following. Chief Complaint: [Facility Name] accidentally gave patient the incorrect insulin dosing. Resident #1 came to the ER via EMS (Emergency Medical Services). Episode onset 8:30 a.m .Context: Erroneous medication by staff. The incident was reported. The incident was witnessed/reported by a caregiver .Patient stated they (the facility) gave her a sugar drink . Patient is an [AGE] year old female with past medical history of insulin-dependent type 2 diabetes who usually takes 13 units of long-acting insulin at night and 10 units regular insulin with meals. EMS reports [Facility Name] accidentally gave patient the incorrect insulin dosing in addition to her 10 units regular insulin with her breakfast this morning they also gave her 40 units of long-acting Lantus, she usually takes 13 units of Lantus in the evening only. She had this medication given to her while eating breakfast, and the patient states that they gave her a sugar drink after the medication error was noticed. EMS reports this sugar drink was Ensure. Patient is otherwise asymptomatic. Physical Exam revealed patient in no acute distress, vital signs stable, with benign exam. Will check Accu-checks (blood sugars), labs.Patient is resting comfortably in bed on reexam, would like to be discharged back to [Facility Name]. Her sugars have stabilized. (this provider) recommended that they do Accu-Checks every hour to ensure no hypoglycemic episodes, and recommended that the patient snack frequently throughout the day to try to maintain sugars. She is given strict ER return precautions.Final diagnoses: Insulin overdose, accidental or unintentional, initial encounter. Resident #1 arrived to the ER at 9:21 a.m. and discharged at 2:34 p.m. Resident #2's December 2025 Medication Administration Record/Treatment Administration Record (MAR/TAR) directed staff to inject:a. Insulin Glargine (long acting insulin(24 hours)) 40 units subcutaneously twice a day. On 12/5/25 at 7:00 a.m., Staff B entered her initials as administering this insulin. b. Humalog (short acting insulin) 10 units subcutaneously before meals. On 12/5/25 at 7:30 a.m., Staff B entered her initials as administering this insulin.Resident #1 received both of Resident #2's insulins the morning of 12/5/25. Resident #1's December MAR/TAR directed staff to inject Insulin Glargine 13 units in the evening. This is the only insulin Resident #1 receives. It was administered on 12/4/25 evening. A Nurses Progress Note dated 12/5/25 at 8:40 a.m., documented that a phone call was placed to 911 requesting a resident transfer to the ER for potential hypoglycemia and observation per verbal order from a facility provider, Resident #1 is her own responsible party and aware of the transfer. Current blood sugar is 177. REsident #1 is alert and oriented X 3 and drinking 120 mls (milliliters) house supplement A Nurses Progress Note dated