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	09/19/2024

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

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on observation, family interview, staff interview, and clinical record review the facility failed to ensure resident dignity for 2 of 3 residents reviewed (Residents #16 & #52). The facility reported a census of 72 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #52 dated 6/27/24 documented diagnoses that included dementia, anxiety, and depression. A Brief Interview for Mental Status (BIMS) assessment was coded, not completed resident rarely/never understood. The Care Plan focus and intervention initiated 1/11/23 documented self-care performance deficits related to activity intolerance, aggressive behavior, confusion, dementia, fatigue, limited mobility. Resident #52 was totally dependent on two staff for dressing. In an interview on 9/18/24 at 10:30 AM Resident #52's responsible party relayed they had reported on two occasions staff brought Resident #52 into the main dining room without pants and only a blanket, Resident would be mortified to know he was exposed. They relayed this to the facility social worker, Staff B. On 9/18/24 at 7:02 PM in an interview with the Administrator and the facility social worker, Staff B relayed she did not remember if was reported, she would have to look at some notes. On 9/18/24 at 7:30 PM the Administrator revealed a grievance form was completed, had been misplaced and just found, was not sure who completed the form. A document titled Resident/Resident Representative, Grievance Complaint form for Resident #52, dated 8/2/24 documented family reported again resident was still going to the dining room area without pants on, there is not much dignity if he doesn't have pants on. 48374 (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

2. Review of Resident #16's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored 11 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated moderately impaired cognition. Per this assessment, the resident had diagnoses of heart failure, coronary artery disease, renal insufficiency, and diabetes. The MDS documented the resident required extensive assistance of 2 staff physical assistance. The resident had impaired and limited range of motion in lower extremities and was dependent in toileting hygiene, bathing, and dressing lower extremities.

The Care Plan for Resident #16 dated 6/14/2023 and revised on 8/15/2024 reflected the resident had an ADL self-care performance deficit. Bathing and showering the resident was extensive assist of 2 staff to provide cares. The resident was also an extensive assist of 2 staff for repositioning and turning. The resident was an assist of 2 for dressing.

During an observation on 09/17/24 at 11:16 AM, Staff K, Licensed Practical Nurse (LPN) entered Resident #16's room to apply Triad Hydrophilic cream to the resident's buttocks. She prepared wash clothes, cream, soap, and gloves on a covered bed table off to the side of the bed. Staff K rolled the resident over on her left side. When Staff K rolled the resident she learned the resident had had a bowel movement and was soiled. Staff K advised she asked a CNA to come in and assist but no one had shown up yet. Staff K continued to hold the resident up on her side waiting for a staff member to assist. The facility Director of Nursing (DON) came in and advised Staff K she needed assistance and left the room to get staff. Staff L, Certified Nursing Assistant (CNA) entered the room to assist. The DON also returned and also observed the resident cares.

Staff L proceeded to clean up Resident #16. Several times throughout the process the resident advised her buttocks itched. I just itch and itch and itch and as she was saying this she itched her buttocks with her bare hands several times. She was not provided an opportunity to wash or sanitize her hands. During peri care both staff members removed their gloves several times and washed their hands and donned clean gloves. Once the resident's peri care was completed both Staff L and Staff K tried to remove the resident's soiled dress off over her head. While the resident laid on her bed staff asked her to rest her arms above her head on the pillow. The two staff members then pulled the dress up over her head and then had a very difficult time getting her arms out. Staff attempted to get her arms out through the neck holes. Both staff faced some resistance in getting the resident's arms out of the dress as the material of the dress did not stretch or flex easily. Once the resident's dress was removed Staff L went to the closet and looked for something for Resident #16 to put on and while doing so the resident was laying there with no clothes on completely exposed while the CNA found something for the resident to put on. Staff K handed the soiled dress over to the CNA who placed the soiled laundry in the garbage and washed hands and changed gloves to put the resident's clean dress on her. When peri care was completed Resident #16 was not offered to wash or sanitize her hands. Staff then picked up the dirty linen and it was put in a garbage bag, washed hands, put on clean gloves and resumed making the bed. Staff L adjusted her incontinent pads on her bed, applied new gloves and got trash bags out of the trash can and picked up soiled items and placed in one plastic bag and picked up her dress and put it in the other trash bag. She then removed gloves and washed her hands before leaving the room. The resident was not asked or assisted in washing her own hands.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/17/24 at 11:53 AM The facility DON was interviewed regarding her observations and expectations. She advised it is her expectation that staff members enter resident rooms prepared for various situations where a resident is a two person assist, not begun the care until the other worker was present. I would expect staff to be more prepared for the whole peri-care process. I'm going to be honest, that procedure wasn't up to my expectations from the start. The DON shared she is developing a skills fair for staff and will be implementing that as soon as possible. When staff changed the resident's clothing they should have had the clothing laid out close to the resident to avoid a delay and the resident should have been covered with a sheet to avoid her being completely naked in front of everyone in the room. The DON advised she also expected staff to wash the resident's back when changing her. When the resident's dress was removed staff should have taken out one arm first instead of the way they did it due to making it awkward for the resident. The DON also advised she expected staff to offer hand washing and sanitizing after care is provided. 09/17/24 at 1:20 PM When queried, Staff L advised she would have typically had the resident wash her hands or at least give her hand sanitizer but she did not notice her scratch her buttocks and in this situation she was nervous. She also advised she should have pulled the clean sheet over the resident to respect her privacy and not had her lie naked. 09/18/2024 at 09:47 AM Follow up interview with Resident #16 she advised she was uncomfortable when staff did not cover her with a sheet or put something over her while looking for clothing for her. She did not realize she had been scratching buttocks and she has hand sanitizer on the tray table but would have thought staff would have offered it to her. 09/19/24 at 11:34 AM Staff K was queried about the procedure observed. She advised she did not anticipate the resident being dirty so she had to get someone to help her. She advised we probably had her exposed too long and if I had been thinking I would have pulled the sheet over her and got her covered. Staff K advised she was going to be a treatment and didn't realize she had to do the whole peri-care. When asked, Staff K also advised they should have offered to wash and sanitize the resident's hands before leaving the room. 09/19/2024 The undated Facility Policy titled, Nursing Facility Abuse Prevention Identification, Investigation and Reporting Policy documents the following: # 15. PERSONAL DEGRADATION is a willful act or statement by a caretaker intended to shame, degrade, humiliate, or otherwise harm the personal dignity of a dependent adult, or where the caretaker knew or reasonably should have known the act or statement would cause shame, degradation, humiliation, or harm to the personal dignity of a reasonable person. Personal Degradation includes the taking, transmission or display of an electronic image of a dependent adult by a caretaker, where the caretaker's actions constitute a willful act or statement intended to shame, degrade, humiliate, or otherwise harm the personal dignity of the dependent adult, or where the caretaker knew or reasonably should have known the act would cause shame, degradation, humiliation, or harm to the personal dignity of a reasonable person.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 46513 Based on resident interview, family interview, staff interview, clinical record and documents review the facility failed to include resident in decision making, denied resident right to be informed and choose options affecting care for 1 of 6 resident reviewed for choices (Resident #19). The facility reported a census of 72 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #19 dated 6/26/24 revealed diagnoses, End stage renal disease (ESRD), anxiety and depression. A Brief Interview for Mental Status (BIMS) assessment scored 15 out of 15 indicating no cognitive impairment. The care plan focus initiated 5/1/24 for Resident #19 directed staff to discuss with resident any concerns related to loss of independence, decline in function. Interventions also included resident teaching should include disease progression. Additional focus area initiated 3/8/24 revealed resident is independent for meeting emotional, intellectual, physical and social needs. A Durable Power of Healthcare document dated 7/31/12 for Resident #19 documented allows family member (attorney in fact/agent) the power to make health care decisions. The power exists only when resident is unable to make those health care decisions. In an interview on 09/16/24 at 02:41 PM Resident #19 relayed he did have trouble with swallowing about six months ago but felt had improved but still is served meat that is ground that is not appetizing, has been asking for months for a reevaluation for the diet change. Resident also reported, did not recall any recent offer to participate in his care plan meeting. In an interview on 9/18/24 at 9:20 AM Resident #19 relayed again dissatisfaction with the ground meat at meals, stated is no longer having any difficulty with swallowing, stated no one listens to me. A Progress note dated 8/20/24 at 3:05 PM titled Nutrition/Dietary note relayed Resident #19 does not always eat the ground meat, complained of not getting enough to eat, frustrated with limited options, relayed does not like ground meat, had been consuming some foods not allowed with no concerns. Recommended speech therapy to determine if diet can be advanced. In an interview on 9/18/24 at 9:45 with Speech Therapist, Staff F relayed resident order for ground meat was given at the hospital just prior to nursing facility admit and had not been reevaluated again. Staff F stated her understanding the Power of Attorney, POA was contacted and does not want to pay the $40.00 copay, so there has been no reevaluation or change from the ground meat. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 09/18/24 12:51 PM with the Director of Rehabilitation, Staff G relayed had received the new order from the dietician on 8/21/24 for speech evaluation to evaluate swallowing related to resident desire to upgrade his diet. Process explained by staff G to proceed with the evaluation included, the request goes to the administrator who gets insurance and any approvals needed. On 9/5/24 she had not gotten a response and followed up with the administrator who directed to use the same insurance as he had in the past that required a 20% coinsurance even though the clinical record noted Medicaid approved. Staff G called the Power of Attorney to move the process forward and did not get an approval, she understood it was due to the co-pay. On 9/18/24 at 4:15 PM Emergency contract #2 relayed Resident #19 liked to discuss everything with family included emergency contact #1 before making any decisions. Stated there is a POA document completed many years ago that directs decision makers when Resident #19 cannot make a decision but did not feel the time had come for that and voiced, a swallowing evaluation would be beneficial for Resident #19 On 9/18/24 at 4:02 PM Resident #19 emergency contact #1 reported the facility contacted him about approval for speech therapy and had been confused about this, since Resident #19 had no troubles with his speech. Emergency contact #1 relayed he did not know speech therapy evaluated swallowing and was well aware how unhappy resident was with the ground meat diet, further revealed the ground meat order was created due to ulcers in residents throat and felt had resolved. Relayed, Resident #19 can make decisions, he is not that far gone. Relayed is confused with the nursing home process of not including Resident #19 in making decisions affecting him. On 9/18/24 at 2:40 PM the Administrator acknowledged decisions for Resident #19 care was directed to family/emergency contacts listed as POA by the facility. Confirmed resident was not given a choice about speech therapy and was not updated when denied the speech evaluation . The administrator responded she did not know if the power of attorney was in effect giving the family members the right to make all decisions. The administrator felt it was appropriate to reach out to family for decisions since family member was listed in the admission papers.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 48886 Based on clinical record review and staff interview, the facility failed to notify the Long Term Care (LTC) Ombudsman for 1 of 3 residents who transferred to the hospital (Resident #5). The facility reported a census of 72 residents. Findings include: Review of the facility's computer software program used for electronic medical record documentation revealed Resident #5 had discharged from the facility on 5/4/24, and hospitalized until they reentered the facility on 5/7/24. The clinical record lacked documentation of notification to the LTC Ombudsman Resident #5 had discharged to the hospital as required by federal regulation. During an interview 9/18/24 at 4:18 PM, the Administrator advised the LTC Ombudsman was not notified of Resident #5's transfer to the hospital in May of 2024. The Administrator stated an expectation the facility notify the LTC Ombudsman when a resident transfers to the hospital. The Administrator advised the facility does not have a policy with regard to notification to the Ombudsman, they follow regulations.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. 48886 Based on clinical record review, staff interview, and policy review, the facility failed to notify the resident and the resident's representative of the facility policy for bed hold, including reserve bed payment, for 1 of 3 residents who were reviewed for hospitalization (Resident #5). The facility reported a census of 72 residents. Findings include: Review of the facility's computer software program used for electronic medical record documentation revealed Resident #5 discharged from the facility on 4/4/24, and hospitalized until they reentered the facility on 4/6/24. In addition, the resident discharged from the facility on 5/4/24, and hospitalized until they reentered the facility on 5/7/24. The clinical record lacked documentation, either in writing or verbally, of notification to the resident or the resident's responsible party of the facility policy for bed hold, including reserve bed payment, when Resident #5 discharged and transferred to the hospital on 4/4/24 and on 5/4/24, with an anticipated return. During an interview 9/18/24 at 4:18 PM, the Administrator acknowledged a bed hold was not completed for the hospitalization in April or May of 2024 for Resident #5. The Administrator stated an expectation a bed hold is completed when a resident transfers to the hospital and explained and signed by the resident or their representative. Review of the facility bed hold policy, dated 8/10/03, documented the facility will inform the resident or legal representative of their bed-hold policy and provide a copy of the policy upon admission and prior to, or as soon as possible, after transfer or temporary discharge.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48886 Based on clinical record review, staff interview, and policy review, the facility failed to fully review and revise the comprehensive Care Plan for 1 of 5 residents who were sampled for Care Plan review (Resident #5). The facility reported a census of 72 residents. Findings include: The Minimum Data Set (MDS) for Resident #5, dated 8/29/24, documented a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. The MDS further documented diagnoses to include medically complex conditions, cancer, non-Alzheimer's dementia, anxiety disorder, and depression. The MDS further revealed the resident was taking an antidepressant medication. A review of the electronic health record (EHR) for Resident #5 revealed an order for Remeron Oral Tablet 15 milligram (MG) (Mirtazapine) to be given by mouth at bedtime for depression, ordered on 4/11/24. The EHR for Resident #5 revealed diagnoses of Major Depressive Disorder, Depression, unspecified, and Anxiety Disorder, unspecified. The Care Plan for Resident #5, with a revision date of 9/11/24, did not include a focus area, goal, or an interventions/tasks area for depression or antidepressant medication. During an interview 9/18/24 at 3:00 PM, the Assistant Director of Nursing (ADON), MDS coordinator and Director of Nursing (DON) stated they realized the anti depressant Resident #5 had been prescribed since April of 2024 was not on the treatment administration record (TAR) for monitoring for signs and symptoms of the antidepressant. The ADON added the monitoring to the TAR in August after realizing this was not present in the TAR and obtained an order for this. The ADON stated this should have been added to the TAR after the resident was prescribed the antidepressant in April . The MDS coordinator advised the anti-depressant was not added to the Care Plan after this was prescribed in April of 2024. The MDS coordinator advised this should have been added to the Care Plan and the comprehensive Care Plan should have been reviewed and revised, with a focus area added, as well as a goal and interventions/tasks, to include monitoring for adverse signs and symptoms of the anti depressant. Review of the facility Care Plan Team policy, dated 8/10/03, documented the Care Plan team will be responsible for reviewing Care Plans to assure that treatment objectives have measurable outcomes and timetables and they reflect the resident's medical, nursing, and psychosocial assessment.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 46513 Based on observation, staff interview, resident interview, and policy review the facility failed to follow the diet order for 1 of 3 residents reviewed on therapeutic diet (Resident #19). The facility reported a census of 72 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #19 dated 6/26/24 revealed a therapeutic diet ordered. Diagnoses included End state Renal Disease (ESRD). A Brief Interview for Mental Status (BIMS) assessment scored 15 out of 15 indicating no cognitive impairment. The Care Plan focus initiated 3/5/24 documented nutrition risk related to ESRD on dialysis, food intolerances, and therapeutic diet. Direct staff to serve diet as ordered. Documented double servings eggs, cereal at breakfast that was added on 4/3/24. In an interview and observation on 9/17/24 at 12:59 PM Resident #19 revealed his lunch plate, over half the plate full of food. Resident relayed he could not eat this, the meat was terrible, couldn't eat the meal other than a few bites. Relayed sauerkraut was awful and having that on the plate made it all taste bad. Relayed rarely gets what he ordered and often gets what he should not have. In an interview on 9/18/24 at 9:20 AM, Resident #19 relayed they got one egg and sausage gravy with a biscuit for breakfast and hot cereal this morning. Relayed the egg portion was smaller and smaller. In an interview on 09/18/24 at 10:29 with the Dietician, Staff C, relayed resident should be served the special renal diet and double protein at meals that included double eggs in the morning. Staff C acknowledged resident should not have been served sauerkraut due to the high sodium. Relayed the alternative on the menu for renal diet was roast beef and acknowledged resident was not served the food per the menu alternative. Staff C acknowledged the resident should get extra eggs and the sausage gravy he had this morning was not part of the renal diet. The facility provided a document titled Diet Policy, not dated, that stated the renal diet limits the use of high potassium, high sodium and high phosphorus containing foods. This diet may be appropriate for individuals undergoing dialysis. For dialysis residents, extra protein at mealtime or between meals may be recommended.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 46513 Based on clinical record review, resident interview, staff interview, and dialysis transfer agreement the facility failed to ensure pre and post dialysis assessments were completed for 1 of 1 resident reviewed for dialysis (Resident #19). The facility reported a census of 72 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #19 dated 6/26/24 revealed a diagnosis of End stage renal disease (ESRD). A Brief Interview for Mental Status (BIMS) assessment scored 15 out of 15 indicating no cognitive impairment. The Care Plan focus initiated 3/1/24 documented, Resident #19 needed hemodialysis related to renal failure, scheduled weekly on Monday, Wednesday, and Friday, documented the resident would have immediate intervention should any signs or symptoms of complications from dialysis occur. On 09/16/24 at 02:29 PM, Resident #19 confirmed long term dialysis and history of health complications resulted in nursing home placement this year, could not recall a pattern of assessments completed relating to dialysis appointments. A Clinical record review on 9/17/24 revealed the required pre and post dialysis assessments were not completed, not found in the resident records. On 09/19/24 at 11:10 AM the Director of Nursing confirmed there are was no specific assessment for required pre and post dialysis assessments and was aware they should be done. The Nursing Home Dialysis Transfer agreement dated 4/12/22 documented the facility shall ensure appropriate information to accompany the resident at time of transfer to include any mental or physical condition changes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886 Based on observation, clinical record review, staff interview, and policy review, the facility failed to provide a sanitary environment to help prevent the development and transmission of communicable diseases and infections during dining and during wound care for 2 of 2 residents reviewed for wound care (Resident #16 and #52). The facility reported a census of 72 residents. Findings include: 1. During an observation 9/17/24, from 12:11 PM to 12:45 PM, in the main dining hall, Staff I, Certified Nursing Assistant (CNA), assisted three residents with cutting up food on their plates, two residents at one table, one at another table, assisted two with their first bites, touched their dessert cup with fingers on the inside of the cup. Staff I did not sanitize hands in between residents. Staff I continued to move back and forth between two residents at one table with giving them bites of their food without sanitizing hands in between residents. Staff I then went to another table and assisted another resident with cutting up their food and did not sanitize hands. Staff I was observed touching tables, backs of chairs, and resident silverware. Staff I then went to another table and assisted another resident take a bite of food, Staff I did not sanitize hands. Staff I then got up to get another resident at another table a cup of coffee, put sugar packets in the coffee, touched the rim of the coffee cup, placed it down for a resident, touching the table and the resident's silverware. Staff I then went to another table and assisted a resident take a bite of food, then assisted another resident at this table with cutting up their food with their silverware. Staff I did not sanitize hands. Staff I continued to assist a resident with taking a bite of food, touched the table top with both hands. Staff I then went to another table and assisted a resident to take a bite of food, then assisted another resident at this same table take a bite, did not sanitize hands. Staff I then went to another table, touched her mask, then brought a chair over to the table to sit down, sat in between two residents, went back and forth between the residents assisting them to take a bite of food, did not sanitize hands, touched the table and silverware. Staff I then got up from the table, went to the nursing station and retrieved two straws, moved the back of a wheelchair for a resident and sat down at the table between two residents. Staff I removed the straws out of the paper wrapper, touched straws, put the straws into resident's cups, touched the rim of one cup and the portion of the straw going into the cup. Assisted another resident take a bite. Staff I went back and forth between the residents assisting them to take a bite. Staff I touched the rim of a cup to bring to a resident's mouth to take a drink. Staff I did not sanitize hands. Staff I then got up from the table, went to touch a key pad at the front door to let someone in, then sanitized hands. Staff I returned to the table to sit between two residents, assisted one resident with taking a bite of food. Staff I then got up from the table, went to another table, put both hands down on table, came back to other table, sat down again and began assisting a resident to take bites, touching silverware, did not sanitize hands, touched mask, then touched silverware again to help resident take a bite. Moved dessert cup, touching inside rim, touched rim of a glass to assist a resident take a drink. Assisted resident to eat their dessert, out of the dessert cup and touched the rim. Did not sanitize hands. During an interview 9/17/24 at 12:51 PM, Staff I stated she will sanitize hands normally in between residents and after touching surfaces. Staff I stated today they did not sanitize as often as they should have, acknowledged should have sanitized after touching dirty surfaces and touching cups, silverware, mask, straws and table, and in between assisting residents. (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	09/19/2024

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation 9/17/24, between 1:05 PM to 1:11 PM, Staff J, CNA, carried a room tray from the dining hall down the CR hallway. The food on the tray was not covered. Staff J carried the tray down the hallway to a cart at the end of the hallway and put it on a cart to be delivered to a resident's room. The CR hallway has 21 residents Covid positive, some residents had their doors partially open. Staff J returned to the dining hall and carried two more trays of food down the CR hallway and placed them on the cart at the end of the hallway, the food was not covered. Staff J returned to the dining hall and carried another tray of food down the CR hallway, placed the tray on the cart at the end of the hallway, the food was again not covered. During an interview 9/17/24 at 2:39 PM, Staff J advised there were four food trays today brought down to the dining room in an insulated cart without the cover over the food. Staff J advised she did not have a cover in the dining room to cover the food and carried the tray down the hallway without the food being covered. Staff J stated the food should be covered when transported down a hallway. Staff J advised there are more room trays than normal due to a Covid outbreak in the CR hallway. During an interview 9/18/24 at 1:30 PM, the Certified Dietary Manager (CDM) advised all food transported in the hallway to residents in their rooms need to be covered. The CDM stated they did run out of domes that cover the plates yesterday on the CR hallway. She instructed staff to use another plate, however acknowledged food was plated and set on trays in the dining room to be brought to residents in their room that was not covered. The CDM believed staff would cover the plate with another plate before taking it down the hallway to a room. The CDM stated an expectation that food is covered while being transported in the hallway. During an interview 9/18/24 at 4:14 PM, the Administrator stated an expectation that staff sanitize their hands in between serving residents food and touching dirty surfaces or items such as masks on their face. The Administrator further stated an expectation food is covered while transported in the hallway to serve to a resident in their room. The Administrator advised the facility does not have a policy for dining, they refer to infection control and standard precautions. Review of the facility Infection Control Program documented in a Remember section, handwashing (hand hygiene) is the single most important precaution to prevent the transmission of infection from one person to another. Wash hands with soap and water before and after each resident contact, and after contact with resident belongings and equipment. Alcohol-based hand rub may be used if hands are not visibly soiled. 48374 2. Review of Resident #16's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored 11 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated moderately impaired cognition. Per this assessment, the resident had diagnoses of heart failure, coronary artery disease, renal insufficiency, and diabetes. The MDS documented the resident required extensive assistance of 2 staff physical assistance. The resident had impaired and limited range of motion in lower extremities and was dependent in toileting hygiene, bathing, and dressing lower extremities. The Care Plan for Resident #16 dated 6/14/2023 and revised on 8/15/2024 reflected the resident had an ADL self-care performance deficit. Bathing and showering the resident was extensive assist of 2 staff to provide cares. The resident was also an extensive assist of 2 staff for repositioning and turning. The resident was an assist of 2 for dressing. (continued on next page)

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/17/24 at 11:16 AM, Staff K, Licensed Practical Nurse (LPN) entered Resident #16's room to apply Triad Hydrophilic cream to the resident's buttocks. She prepared wash clothes, cream, soap, and gloves on a covered bed table off to the side of the bed. Staff K rolled the resident over on her left side. When Staff K rolled the resident she learned the resident had a bowel movement and was soiled. Staff K advised she asked a CNA to come in and assist but no one had shown up yet. Staff K continued to hold the resident up on her side waiting for a staff member to assist. The facility Director of Nursing (DON) came in and advised Staff K she needed assistance and left the room to get staff. Staff L, Certified Nursing Assistant (CNA) entered the room to assist. The DON also returned and also observed the resident cares. Staff L proceeded to clean up Resident #16. Several times throughout the process the resident advised her buttocks itched. I just itch and itch and itch and as she is saying this she itched her buttocks with her bare hands several times. She was not provided an opportunity to wash or sanitize her hands. During peri care both staff members removed their gloves several times and washed their hands and donned clean gloves. Once the resident's peri care was completed both Staff L and Staff K tried to remove the resident's soiled dress off over her head. While the resident laid on her bed staff asked her to rest her arms above her head on the pillow. The two staff members then pulled the dress up over her head and then had a very difficult time getting her arms out. Staff attempted to get her arms out through the neck holes. Both staff faced some resistance in getting the resident's arms out of the dress as the material of the dress did not stretch or flex easily. Staffed K handed the soiled dress over to the CNA who placed the soiled laundry in the garbage and washed hands and changed gloves to put the resident's clean dress on her. When peri care was completed Resident #16 was not offered to wash or sanitize her hands. Staff then picked up the dirty linen and it was put in a garbage bag, washed hands, put on clean gloves and resumed making the bed. Staff L adjusted her incontinent pads on her bed, applied new gloves and got trash bags out of the trash can and picked up soiled items and placed in one plastic bag and picked up her dress and put it in the other trash bag. She then removed gloves and washed her hands before leaving the room. The resident was not asked or assisted in washing her own hands. 09/17/24 at 11:53 AM The facility DON was interviewed regarding her observations and expectations. She advised it is her expectation that staff members enter resident rooms prepared for various situations where a resident is a two person assist and not begun the care until the other worker was present. I would expect staff to be more prepared for the whole peri-care process. I'm going to be honest, that procedure wasn't up to my expectations from the start. The DON shared she is developing a skills fair for staff and will be implementing that as soon as possible. When staff changed the resident's clothing they should have had the clothing laid out close to the resident to avoid a delay. The DON advised she also expected staff to wash the resident's back when changing her. When the resident's dress was removed staff should have taken out one arm first instead of the way they did it due to making it awkward for the resident. The DON also advised she expected staff to offer hand washing and sanitizing after care is provided. 09/17/24 at 1:20 PM When queried, Staff L advised she would have typically had the resident wash her hands or at least give her hand sanitizer but she did not notice her scratch her buttocks and in this situation she was nervous. 09/18/2024 at 09:47 AM Follow up interview with Resident #16 she advised she did not realize she had been scratching her buttocks and she had hand sanitizer on the tray table but would have thought staff would have offered it to her. (continued on next page)

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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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/19/24 at 11:34 AM Staff K was queried about the procedure observed. She advised she did not anticipate the resident being dirty so she had to get someone to help her. Staff K advised she was going to be a treatment and didn't realize she had to do the whole peri-care. When asked, Staff K also advised they should have offered to wash and sanitize the resident's hands before leaving the room. 09/19/2024 The undated policy titled Infection Control Program- Handwashing Procedure documents the following: Staff will be educated, trained, and monitored for proper hand washing as follows: When coming on duty When hands are visibly soiled (hand washing with soap and water); before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice); Before and after performing any invasive procedure (e.g., finger stick blood sampling); Before and after entering isolation precaution settings; Before and after eating or handling food (Hand washing with soap and water); Before and after assisting a resident with meals (hand washing with soap and water); Before and after assisting a resident with personal care (e.g., oral care, bathing); Before and after handling peripheral vascular catheters and other invasive devices; Before and after inserting indwelling catheters; Before and after changing a dressing; Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse or blood pressure, and lifting a resident); After personal use of the toilet (hand washing with soap and water); Before and after assisting a resident with toileting (hand washing with soap and water); After contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella, and C. Difficile (hand washing with soap and water); After blowing or wiping nose; After contact with a resident's mucous membranes and body fluids or excretions; After handling soiled or used linens, dressings, bedpans, catheters and urinals; After handling soiled equipment or utensils; After performing personal hygiene (hand washing with soap and water); After removing gloves or aprons; and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	After completing duty. Consistent use by staff of proper hand washing practice and techniques is critical. 46513 3. The Medication Administration Record (MAR) for Resident #52 directed treatment, start date 9/11/24 [NAME] cream to bilateral legs once daily every day shift for skin integrity and a start date of 8/31/24 apply gentamicin ointment 0.1 topically to open areas on left toes every shift, cleanse open areas on top left toes with wound spray, apply ointment and cover. During an observation on 09/18/24 at 08:58 AM, Registered Nurse (RN) Staff #D and Licensed Practical Nurse (LPN) Staff #E entered resident #52 room. Staff D revealed Resident #52 had lower leg edema that caused open areas on left toe that required treatment of an antibiotic ointment and had superficial open areas on the right leg, treated with a cream. Staff D completed hand hygiene, gowned, masked, and gloved before start of the treatment. Staff D removed the bandages from the left foot and right leg, gloves changed, toes and leg were cleansed, gloves changed, ointment to the toes and cream applied to legs, gloves changed and kerlix (gauze) wrap applied, gloves were removed and at no time was hand sanitizer or hand hygiene done after removing the gloves and putting on another pair during the treatment process. In an interview on 9/18/24 at 9:10 AM that followed the dressing change on Resident #52 lower extremities, Staff D and Staff E acknowledged they should have used hand sanitizer after removing gloves and donning the new pair during the dressing change. In an interview on 9/18/24 at 7:20 PM with the DON and the administrator, both acknowledged the importance of hand hygiene for infection control.