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 _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBROOK HEALTHCARE AND REHABILITATION CENTER	6420 COUNCIL STREET NE CEDAR RAPIDS, IA 52402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date:_____ The following information is related to the investigation of facility reported incidents #120003-I and #120012-I and complaints #117793-C, #118271-C, #118235-C, & #118983-C conducted from April 8 - 10, 2024. Facility reported incident #120003-I was substantiated. Facility reported incident #120012-I was substantiated. Complaint #117793-C was substantiated. Complaint #118271-C was not substantiated. Complaint #118235-C was not substantiated. Complaint #118983-C was substantiated. See the Code of Federal Regulations (42FR) Part 483, Subpart B-C.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		

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 _____	C 04/10/2024

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 656	Continued From page 1 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interviews, the facility failed to follow the resident's Care Plan for 1 of 11 residents reviewed (Resident #6). The facility reported a census of 78 residents. Findings include:	F 656		

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 _____	C 04/10/2024

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 656	Continued From page 2	F 656		

The MDS (Minimum Data Set), an assessment tool, dated 1/4/2024, revealed Resident #6 had impaired cognitive abilities with long and short term memory impairment. The resident was dependent on staff to transfer from one surface to another, had one stage two pressure ulcer and incontinent of bowel and bladder. The resident had diagnoses including dementia and depressive disorder.

The resident's Care Plan identified the resident had a risk for pressure sore development related to immobility initiated 7/13/2023. On 11/16/2023 the Care Plan indicated a stage II coccyx wound healed. The Care Plan directed staff to assist resident to shift weight in wheel chair every 15 minutes, educate resident/family/caregivers as to causes of skin breakdown including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. The Care Plan instructed staff to follow facility policies/protocols for the prevention/treatment of skin breakdown, inform the resident/family/caregivers of any new area of skin breakdown, monitor nutritional status and provide assistance to turn/reposition at least every 2 hours, more often as needed or requested.

The resident's weekly pressure injury record dated 4/3/2024 revealed the resident had a stage I coccyx wound that measured 0.6 by 0.1 centimeter. The report indicated the healing wound appeared covered with white moist skin.

The facility Skin Log received on 4/8/2024 revealed Resident #6 had a Stage III coccyx wound.

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 _____	C 04/10/2024

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 656	Continued From page 3	F 656		

Observation on 4/8/2024 at 8:40 A.M. revealed Resident #6 seated in a wheel chair near the nurse's station and the dining room entrance. Observation at 10:40 A.M. and 11:12 A.M. revealed the resident continued to sit in the wheel chair in the same location.

Staff D, CNA revealed staff positioned the resident near the nurse's station for close supervision.
At 11:15 A.M. Staff D and Staff B, CNA's reported they assisted the resident up from bed at 7:00 A.M. and had not provided incontinence cares or repositioning since that time.

At 11:20 A.M., Staff E and Staff B assisted the resident to bed and provided check and change and incontinence cares. Staff F, LPN (Licensed Practical Nurse) applied Triad cream (for wound care) as prescribed. The resident's coccyx had a scabbed over area approximately one inch in length. Staff F indicated the wound improved and appeared almost healed. Staff B reported the resident's Care Plan instructed staff to provide check and change every two to three hours.

The facility Skin Care Assessment and Treatment policy dated 9/30/04 included:
Policy - It is the policy of Northbrook Manor Care Center that a resident with any type of skin condition (i.e. red area, skin tears, decubitus ulcers) shall receive appropriate treatment. The treatment will have as its aim to promote healing, prevent infection, and prevent new conditions from arising.
Procedure:
Purpose - This policy has been established to prevent the development of any pressure areas, to care for any existent pressure areas, and to

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 _____	C 04/10/2024

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 656	Continued From page 4 promote skin integrity. Treatment and documentation - All assessed skin conditions will be charted on weekly after the initial finding: 1. The nurse will do skin checks and document weekly as long as a problem area exists. Documentation will be done on appropriate reports. 2. When treatments are done on an open area, the nurse will measure and write a complete assessment weekly. Documentation will be done whenever there is a dressing change. 3. If there is a new skin condition, this will be written on the Skin Condition Report with a place for initialing weekly when completed. Notification: 1. The nurse will notify the physician any significant changes. The physician will be notified immediately of any pressure area and asked for treatment. All treatment orders will be written with specific instructions as to what will be used on the area, how often, for how long and where it is. The physician's order, treatment sheet and labels on any items used must read the same. Preventative routing: If a resident is established to be at risk for skin breakdown, nursing staff will utilize all protocol instituted for resident at a normal risk for skin breakdown. Preventative routine care includes but is not limited to the following: 1. Observe resident daily for condition of skin, paying special attention to bony prominence's. 2. Turn and proper positioning in accordance with a written schedule (at least every 2 hours). A turning wheel will be placed at bedside to remind staff of exact time of last repositioning.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards	F 658		

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 _____	C 04/10/2024

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 658	Continued From page 5 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews, policy review and observations, the facility failed to follow physician's orders for 3 of 3 residents reviewed (Resident #1, #6, #9). The facility reported a census of 78 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated 2/7/2024, Resident #1 had diagnoses which included heart disease, Covid related weakness, and Alzheimer's. The MDS revealed the resident required assistance of 1 staff for transfers, dressing, bathing, and hygiene. The resident utilized a wheelchair and walker to move about the facility. The Resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident had intact cognitive ability. Review of the initial Care Plan dated 1/31/24 indicated Resident #1 was at risk for skin breakdown related to bladder incontinence. The plan directed the staff to provide medications, treatments, and dressings as ordered by the physician. Review of the unsigned Resident Admission Assessment dated 1/31/24 completed 1:15 PM	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 658	Continued From page 6	F 658		

revealed the resident had skin impairments which included a 1 centimeter open area on her left buttock area, redness to abdominal folds, and bruises to the left arm.

Review of a Physician's Order dated 1/31/24 directed the staff to apply Miconazole Antifungal cream 2% to the resident's breast and abdominal area every day and Nystatin Cream 10000 units to breast and abdominal area for yeast once daily.

Review of the February 2024 Treatment Record revealed the following:
a. The staff failed to administer Miconazole Antifungal Cream 2% to the breast/abdomen 4 out of 14 days. (The resident discharged from the facility on 2/14/24).
b. The staff failed to administer Nystatin Cream (anti-fungal medication) to the breast/lower abdominal area 4 out of 14 days.

Review of Resident #1's Progress Notes dated 1/31/24 through discharge on 2/14/24 failed to reveal medication refusals.

2. The MDS dated 1/4/2024 revealed Resident #6 had impaired cognitive abilities with long and short term memory impairment. The resident was dependent on staff to transfer from one surface to another, had one stage two pressure ulcer and incontinent of bowel and bladder. The resident had diagnoses including dementia and depressive disorder.

The resident's Care Plan identified the resident had a risk for pressure sore development related to immobility initiated on 7/13/2023. On 11/16/2023 the care plan indicated a stage II

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 _____	C 04/10/2024

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 658	Continued From page 7	F 658		

coccyx wound healed. The Care Plan directed staff to continue Triad preventative paste three times a day.

The Physician's Order written 11/16/2023 included Triad Hydrophilic Wound Dress External Paste, (Wound Dressings). Apply to buttocks topically three times a day for excoriation.

A review of the resident's February, 2024 TAR (Treatment Administration Record) revealed staff failed to apply the Triad paste for 31 of 87 opportunities. A review of the March, 2024 TAR revealed staff failed to apply the Triad paste for 22 of 93 opportunities. A review of the April, 2024 TAR revealed staff failed to apply the Triad paste for 4 of 24 opportunities.

The resident's weekly pressure injury record revealed staff identified a stage III pressure area on the resident's coccyx that measured 2.3 by 0.6 cm (centimeters) on 11/16/2023. On 4/6/2024 the record revealed the wound measured 0.6 by 0.1 cm.

On 4/8/2024 at 11:30 A.M. Staff F, LPN applied Triad cream to the resident's coccyx. Staff F indicated the area improved, and appeared scabbed over. The area, covered with white moist skin, measured approximately 0.6 cm in length.

3. The MDS dated 1/18/2024 revealed Resident #9 had intact cognitive abilities, ambulated with set up help, and had diagnoses including congestive heart failure and diabetes.

The resident's Care Plan identified the resident had a risk for pressure ulcer development related to disease process, peripheral vascular disease

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 _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBROOK HEALTHCARE AND REHABILITATION CENTER	6420 COUNCIL STREET NE CEDAR RAPIDS, IA 52402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 8	F 658		

and a history of moisture associated skin damage. On 2/2/2024 staff identified the resident had a stage II pressure area on his right hip.

On 2/28/2024 the physician ordered staff to cleanse the right hip area with soap and water, pat dry, apply Silvadene ointment to center, cover with Telfa dressing and Duoderm anchors two times a day.

A review of the resident's March TAR revealed staff failed to administer the Silvadene ointment treatment 9 out of 62 opportunities. A review of the resident's April TAR revealed staff failed to administer the Silvadene ointment treatment 2 out of 16 opportunities.

Staff L, RN/Interim Director of Nurses, on 4/9/24 at 1200, reported working on staff documentation and accountability, she voiced she would expect her staff who administer medications to follow the Physician's Orders as directed.

Review of an undated Medication Pass and Treatments policy directed staff to administer medications according to standard of practice and in a safe manner that will correlate with their daily activities and natural schedules.

The facility Skin Care Assessment and Treatment policy dated 9/30/04 included:
Policy - It is the policy of Northbrook Manor Care Center that a resident with any type of skin condition (i.e. red area, skin tears, decubitus ulcers) shall receive appropriate treatment. The treatment will have as its aim to promote healing, prevent infection, and prevent new conditions from arising.
Procedure:

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 _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBROOK HEALTHCARE AND REHABILITATION CENTER	6420 COUNCIL STREET NE CEDAR RAPIDS, IA 52402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 9 Purpose - This policy has been established to prevent the development of any pressure areas, to care for any existent pressure areas, and to promote skin integrity. Treatment and documentation - All assessed skin conditions will be charted on weekly after the initial finding: 1. The nurse will do skin checks and document weekly as long as a problem area exists. Documentation will be done on appropriate reports. 2. When treatments are done on an open area, the nurse will measure and write a complete assessment weekly. Documentation will be done whenever there is a dressing change. 3. If there is a new skin condition, this will be written on the Skin Condition Report with a place for initialing weekly when completed. Notification: 1. The nurse will notify the physician any significant changes. The physician will be notified immediately of any pressure area and asked for treatment. All treatment orders will be written with specific instructions as to what will be used on area, how often, for how long and where it is. The physician's order, treatment sheet and labels on any items used must read the same.	F 658		
F 676 SS=E	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This	F 676		

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 _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBROOK HEALTHCARE AND REHABILITATION CENTER	6420 COUNCIL STREET NE CEDAR RAPIDS, IA 52402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 10	F 676		

includes the facility ensuring that:

§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...

§483.24(b) Activities of daily living.
The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:

§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,

§483.24(b)(2) Mobility-transfer and ambulation, including walking,

§483.24(b)(3) Elimination-toileting,

§483.24(b)(4) Dining-eating, including meals and snacks,

§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, policy review and staff interviews, the facility failed to provide 4 of 5 resident's reviewed with 2 baths weekly (Residents # 3, #4, #5, #6). The facility reported a census of 78 residents.

Findings include:

1. According to the MDS (Minimum Data Set)

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 _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBROOK HEALTHCARE AND REHABILITATION CENTER	6420 COUNCIL STREET NE CEDAR RAPIDS, IA 52402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 11	F 676		

dated 12/14/2023, Resident #3 had diagnoses which included dementia and cerebrovascular insufficiency, and had severely impaired cognitive ability.

The resident's Care Plan indicated the resident transferred with the assistance of two staff and a mechanical lift. Staff were instructed to wash what the resident could not do for herself.

Review of the December, 2023 bath record revealed the resident received two baths during the month from December 1 - December 31, 2023.

2. According to the MDS dated 3/14/2024, Resident #4 had severely impaired cognitive ability, required staff assistance to transfer and ambulate, and had diagnoses including dementia, weakness, and depression.

The resident's Care Plan directed staff to provide a bath/shower/bed bath with the assistance of one staff.

A review of the resident's bath records revealed the resident received one bath in February, 2024 and four baths in March, 2024.

3. According to the MDS dated 1/18/2024, Resident #5 had diagnoses of diabetes and dementia, and long and short term memory impairment.

The resident's Care Plan directed staff to provide the resident with two baths a week and transfer the resident with two staff and the use of a mechanical lift.

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 _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBROOK HEALTHCARE AND REHABILITATION CENTER	6420 COUNCIL STREET NE CEDAR RAPIDS, IA 52402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 12	F 676		

A review of the resident's bath records revealed the resident received no baths the month of February, 2024 and no baths the month of March, 2024.

4. According to the MDS dated 1/4/2024, Resident #6 had long and short term memory impairment and had diagnoses including dementia and depression.

The resident's Care Plan directed staff to provide two staff to transfer the resident and assist with showering.

A review of the resident's bath records revealed the resident received no baths the month of March, 2024.

The facility submitted a memo dated 4/8/2024 that addressed the signing of daily shower sheets. It directed nurses to sign the daily shower sheet, acknowledge the charted refusals, and address skin sheets. It instructed aides to fill out daily shower sheets including resident refusals, and all showers were to be completed prior to leaving at the end of the shift.

On 4/10/2024 at 11:30 A.M., Staff A, Administrator indicated with the increase in the facility's census, they added a bath aide and planned to continue it as they moved forward.

On 4/10/2024 at 9:00 A.M., Staff C, CNA reported she worked as the designated bath aide on 4/10/2024. The facility recently started assigning a bath aide.

On 4/10/2024 at 9:45 A.M., Staff B, CNA reported the facility recently added a designated bath aide

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 _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBROOK HEALTHCARE AND REHABILITATION CENTER	6420 COUNCIL STREET NE CEDAR RAPIDS, IA 52402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 13 position. Prior to the current week, the aides were required to administer showers, often leaving them without a break.	F 676		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews, policy review, and observations, the facility failed to provide appropriate assessments and interventions for 4 of 6 residents reviewed with impaired skin and a change of condition (Residents #1, #6, #8, #9). The facility reported a census of 78 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated 2/7/2024, Resident #1 had diagnoses which included heart disease, Covid related weakness, and Alzheimer's. The MDS revealed the resident required assistance of 1 staff for transfers, dressing, bathing, and hygiene. The resident utilized a wheelchair and walker to move about the facility. The Resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognitive ability.	F 684		

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 _____	C 04/10/2024

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 684	Continued From page 14	F 684		

Review of the initial Care Plan dated 1/31/24 indicated Resident #1 was at risk for skin breakdown related to bladder incontinence. The plan directed the staff to provide medications, treatments and dressings as ordered by the physician.

Review of the unsigned Resident Admission Assessment dated 1/31/24 completed at 1:15 pm revealed the resident had skin impairments which included a 1 centimeter open area on her left buttock area, redness to abdominal folds, and bruises to the left arm.

During an interview with Staff L-RN/Interim Director of Nurses stated she was unable to locate any weekly skin assessments for the resident. Staff L stated this week (week of 4/8/24) they assigned a facility RN to complete weekly skin assessments. Staff L stated the only skin assessment that could be found for Resident #1 was completed upon the resident's admission 1/31/24.

2. According to the Minimum Data Set (MDS) Resident #8 had diagnoses which included cancer, renal insufficiency, and chronic obstructive pulmonary disease. The resident had a Brief Interview for Mental Status (BIMS) score of 9 which indicated moderate cognitive impairment with mood disturbances. The resident required moderate assistance with walking, transfers, and hygiene.

Review of Resident #8's Care Plan dated 3/13/24 indicated the resident had a risk of falls and experienced a fall on 3/13/24 without injuries. The Care Plan failed to inform and address a change of condition following a fall in the facility on

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 _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBROOK HEALTHCARE AND REHABILITATION CENTER	6420 COUNCIL STREET NE CEDAR RAPIDS, IA 52402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 15	F 684		

4/4/24. The resident sustained a closed fracture of the Olecranon process of the right ulna which required hospitalization from April 4-6, 2024.

Observation on 4/9/24 at 1:10 pm revealed the resident in bed with head up slightly. The resident's right hand had extensive edema noted from the wrist to finger tips. The right arm was in a sling as she laid in bed, the right shoulder was protruding upwards with extensive discoloration, purple in color. The resident was noted to have two 2x4 adhesive dressings to an area on the upper right arm, the bandages were noted to be saturated with dark colored substance.

During an interview with Staff F- LPN/Charge Nurse for Resident #8 at 1:25 pm, Staff F was asked about the soiled dressings and the prescribed treatments. The LPN/Charge Nurse stated she came from the hospital with those on and they didn't send any orders regarding the dressings. Staff F was asked if she inquired about the dressings and follow up orders, she denied following up on this. Staff A-Administrator present during this conversation stated the facility will have orders for the wound care in 15 minutes and will assess the wounds.

Review of a Progress Note dated 4/6/24 at 3:05 pm the resident returned from the hospital with a closed fracture of the right ulna. The resident had a splint to the right elbow for stability and support. The hospital reported the splint to remain in place but did not say how long. A wound dressing noted under the splint and staff not able to open and visualize the area, the dressing is intact. The resident verbalized pain with movement and a touch to the arm.

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 _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBROOK HEALTHCARE AND REHABILITATION CENTER	6420 COUNCIL STREET NE CEDAR RAPIDS, IA 52402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 16	F 684		

Review of the Progress Notes dated 4/9/24 at 2:58 pm revealed the following entry by Staff L-RN/Interim DON: This nurse observe soiled dressing just above the wrap and splint on right upper extremity. No orders were received upon return from the hospital. Called Provider's office to clarify. They stated the splint is not to be removed and that there wasn't supposed to be dressing orders due to the wound being under the wrap. This writer explained that part of the wound is exposed above the splint and that the dressing needs changed. This writer ask for triple antibiotic ointment with non-adherent gauze secured with paper tape or roll gauze. Dressing too high on arm to wrap so it was secured with tape. 3 abrasions from the fall were treated and covered. See skin book for size and details. Dark bruising noted around wounds related to the fall and fracture. Closed skin tear noted on inside of right wrist. Steri strips dry and intact. Closed laceration behind right ear intact, resident expresses intermittent pain, mostly when laying head on that area.

Interview with Staff L/RN on 4/9/24 at 1:48 pm revealed she talked to Staff F- LPN who was the responsible nurse for Resident #8 on this day. Staff F-LPN informed Staff L-RN that the resident's right hand is more swollen than yesterday and that she will contact the physician. Staff L-RN admitted there was clearly a lack of assessments on the residents' right hand and bandages to right shoulder and that she will follow up to assure the resident's physician is aware of the situation. Staff L-RN/Interim DON stated on 4/9/24 she completed a thorough skin assessment today, but unable to locate any skin sheets completed upon resident's return from hospital.

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 _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBROOK HEALTHCARE AND REHABILITATION CENTER	6420 COUNCIL STREET NE CEDAR RAPIDS, IA 52402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 17	F 684		

3. The MDS dated 1/4/2024 revealed Resident #6 had impaired cognitive abilities with long and short term memory impairment. The resident was dependent on staff to transfer from one surface to another, had one stage two pressure ulcer and incontinent of bowel and bladder. The resident had diagnoses including dementia and depressive disorder.

The resident's Care Plan identified the resident had a risk for pressure sore development related to immobility initiated on 7/13/2023. On 11/16/2023 the Care Plan indicated a stage II coccyx wound healed. The Care Plan directed staff to continue Triad preventative paste three times a day.

The Physician's Order written 11/16/2023 included Triad Hydrophilic Wound Dress External Paste, (Wound Dressings). Apply to buttocks topically three times a day for excoriation.

The resident's weekly pressure injury record revealed staff identified a stage III pressure area on the resident's coccyx that measured 2.3 by 0.6 cm (centimeters) on 11/16/2023. On 4/6/2024 the record revealed the wound measured 0.6 by 0.1 cm. A review of the records from 11/16/2023 - 4/6/2024 revealed staff failed to assess the resident's pressure injury every week as the policy directed.

4. The MDS dated 1/18/2024 revealed Resident #9 had intact cognitive abilities, ambulated with set up help and had diagnoses including congestive heart failure and diabetes.

The resident's Care Plan identified the resident

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 _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBROOK HEALTHCARE AND REHABILITATION CENTER	6420 COUNCIL STREET NE CEDAR RAPIDS, IA 52402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 18	F 684		

had a risk for pressure ulcer development related to disease process, peripheral vascular disease, and a history of moisture associated skin damage. On 2/2/2024 staff identified the resident had a stage II pressure area on his right hip.

On 2/28/2024 the physician ordered staff to cleanse the right hip area with soap and water, pat dry, apply Silvadene ointment to center, cover with Telfa dressing and Duoderm anchors two times a day.

On 2/7/2024 staff identified the resident had a stage II pressure injury on his right hip that measured 2.2 cm. by 3.0 cm.
A review of the resident's Weekly Pressure Injury Record from 2/7/2024 - 4/3/2024, revealed staff failed to assess the resident's pressure injury every week as the policy directed.

The facility Skin Care Assessment and Treatment policy dated 9/30/04 included:
Policy - It is the policy of Northbrook Manor Care Center that a resident with any type of skin condition (i.e. red area, skin tears, decubitus ulcers) shall receive appropriate treatment. The treatment will have as its aim to promote healing, prevent infection, and prevent new conditions from arising.
Procedure:
Purpose - This policy has been established to prevent the development of any pressure areas, to care for any existent pressure areas, and to promote skin integrity.
Treatment and documentation - All assessed skin conditions will be charted on weekly after the initial finding:
1. The nurse will do skin checks and document weekly as long as a problem area exists.

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 _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBROOK HEALTHCARE AND REHABILITATION CENTER	6420 COUNCIL STREET NE CEDAR RAPIDS, IA 52402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 19 Documentation will be done on appropriate reports. 2. When treatments are done on an open area, the nurse will measure and write a complete assessment weekly. Documentation will be done whenever there is a dressing change. 3. If there is a new skin condition, this will be written on the Skin Condition Report with a place for initialing weekly when completed. Notification: 1. The nurse will notify the physician of any significant changes. The physician will be notified immediately of any pressure area and asked for treatment. All treatment orders will be written with specific instructions as to what will be used on area, how often, for how long and where it is. The physician's order, treatment sheet and labels on any items used must read the same.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, facility investigation report, and staff interviews, the facility failed to supervise 1 of 6 residents reviewed in order to prevent a fall with injury (Resident #4). The facility reported a census of 78 residents.	F 689		

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 _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBROOK HEALTHCARE AND REHABILITATION CENTER	6420 COUNCIL STREET NE CEDAR RAPIDS, IA 52402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 20	F 689		

Findings include:

The MDS (Minimum Data Set) dated 12/14/2023 revealed Resident #4 had severely impaired cognitive abilities, required extensive assistance to transfer from one surface to another, and had a fall that resulted in a major injury. The resident had diagnoses including weakness, depression, and dementia.

Resident #4's Care Plan identified she had a a risk for falls due to confusion, deconditioning, gait/balance problems, incontinence, poor communication, unaware of safety needs, and history of syncope initiated on 10/18/2019. The Care Plan directed staff to provide assistance with all transfers and ambulation initiated on 12/12/2023. The Care Plan identified the resident had an ADL (Activities of Daily Living) self-care performance deficit initiated 10/16/2019. It directed staff to transfer with the assistance of one staff and a 4 wheeled walker initiated 10/18/2019.

The MAR (Medication Administration Record) revealed the resident received Tylenol 650 mg on Dec 13, 2023 at 7:00 A.M. The physician ordered Tylenol 650 mg four times a day for pain control on 12/13/2023. The resident continued to receive Tylenol 650 mg four times a day.

The X-ray report dated 12/12/2023 revealed Resident #4 had an acute complete oblique (broken at an angle) fracture of the distal radius (one of the forearm bones) extending to the distal radial ulnar joint (left wrist) with minimal dorsal angulation of the distal fracture fragment.

On 12/12/2023 the physician ordered a wrist

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 _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBROOK HEALTHCARE AND REHABILITATION CENTER	6420 COUNCIL STREET NE CEDAR RAPIDS, IA 52402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 21	F 689		

splint to be worn at all times, except for bathing or showers, Tylenol 650 mg (milligrams) four times a day and repeat X-ray in four weeks.

The X-ray report dated 1/15/2024 revealed a healing non-displaced fracture.

In a Progress Note dated 12/12/2023 at 1:00 P.M., Staff G, RN documented the resident ambulated with the CNA, lost her balance and fell onto the floor towards the right side. The resident did not hit her head, and she complained of left wrist pain with no swelling or bruising noted at this time. Ice pack applied.

The facility Incident/Accident Report dated 12/12/2023 at 1:00 P.M. completed by Staff G, RN revealed Resident #4 ambulated with a CNA, lost her balance and fell onto the floor on her right side without hitting her head. The resident complained of left wrist pain. Additional comments and/or steps to prevent recurrence: Use walker with ambulating. An additional comment added later stated: Gait belt for all transfers.

The facility Self Report, submitted to DIA (Department of Inspections and Appeals) on 12/12/2023 by Staff M, the former DON (Director of Nursing) included:
Accident with major injury in the main dining room. The resident ambulated in the main dining room with Staff I, CNA. The resident lost her balance and fell toward her right side. She did not hit her head. She complained of left wrist pain without bruising or swelling. The right middle finer had a light purple bruise. Corrective Action Description: Resident will use walker with ambulation.

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 _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBROOK HEALTHCARE AND REHABILITATION CENTER	6420 COUNCIL STREET NE CEDAR RAPIDS, IA 52402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 22	F 689		

Staff I, CNA Witness Statement Summary: was ambulating with resident when resident lost her balance and fell toward her right side.

Staff G, RN Witness Statement Summary: Resident was ambulating in dining room with CNA. Resident lost balance and fell forward toward her right side. She did not hit her head but complained of left wrist pain. No swelling or bruising to wrist. Light bruise to middle finger of right hand.

Staff H, Care Plan Coordinator statement dated 4/10/2024: Gait belt education was provided by Staff right away through the communication binder (5 minute binder), through facility postings at nurses area, and covered in a subsequent nursing meeting.

Staff L, Interim DON submitted a copy of communication from Staff M to all staff to read. "Gait belts are a part of your uniform. They must be used or reprimand will happen." Staff L indicated Staff M wrote the communication after Resident #4's fall.

Staff M also posted a sign at the nurse's stations that read: "Attention all nursing staff. Gait belts are required as part of your uniform. You must have a gait belt on you at all times."

Observation on 4/8/2024 at 12:13 P.M. revealed Staff N, CNA, assisted Resident #4 to the edge of her bed and applied a gait belt around her waist. Staff N assisted the resident to stand with the gait belt and the wheeled walker. Staff N held the gait belt and the resident used the wheeled walker to ambulate with a slow and steady gait to the dining

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 _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBROOK HEALTHCARE AND REHABILITATION CENTER	6420 COUNCIL STREET NE CEDAR RAPIDS, IA 52402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 23	F 689		

room. The resident was cooperative and alert.

On 4/10/2024 at 11:30 A.M., Staff A, Administrator reported working at the facility since January, 2024, and did not work at the facility when Resident #4 fell. She could only provide information that the previous administration reported on line since many of the investigative files were empty.

On 4/10/2024 at 8:30 A.M., Staff G reported working on 12/12/2024 when Resident #4 fell. Staff I, CNA walked with the resident and Staff G did not see her in time to correct her. Staff G did not know the resident used a walker, and thought the resident required light contact assistance with ambulation. Staff G said the resident fell in the dining room and she did the investigation. Staff G did not recall seeing the resident with a gait belt on when she fell. All staff were educated to use gait belts. Signs were placed at the nurse's stations reminding staff they are to have gait belts as a part of the uniform and should be worn at all times. Staff G wrote "use walker with ambulating." Staff H updates the Care Plans. Staff need to use a gait belt with any resident that requires assistance with transfers or ambulation. Staff I had worked at the facility prior to that day. The facility provides new staff with cheat sheets telling them how each resident transfers. Everyone knows the gait belt policy, it is standard nursing practice.

On 4/10/2024 at 8:56 A.M., Staff H, Care Plan Coordinator indicated any resident who transfers or ambulates with assistance requires the use of a gait belt. Staff H reviews each incident, makes sure there is an intervention in place and that it is care planned. When Resident #4 fell, the charge

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 _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBROOK HEALTHCARE AND REHABILITATION CENTER	6420 COUNCIL STREET NE CEDAR RAPIDS, IA 52402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 24	F 689		

nurse's immediate intervention was to "use walker with ambulation." Staff H reviewed the incident and added "gait belt for all transfers." The former DON interviewed staff and the investigation determined Staff I did not use a gait belt when the resident fell. If Staff I had used a gait belt, she would have been able to grab it when the resident started to lose her balance.

On 4/10/2024 at 10:00 A.M., Staff K, CNA reported working on 12/12/2023, however she had no recall of Staff I and no recall of Resident #4's fall. Staff K knew she needed to wear a gait belt at all times and use it with any resident who required assistance of one to transfer and ambulate.

During a phone interview on 4/10/2024 at 10:30 A.M., Staff I reported working on 12/12/2023 when Resident #4 fell, That was her second day at the facility and her first with the resident. Staff I had no cheat sheet and did not know the resident. Staff I reported she walked with the resident from the bathroom to the dining room with a wheeled walker and a gait belt. Staff I held the resident's hand, and stood on her left side. Staff I said the resident also had one hand on the walker. The resident lost her balance and her hand slipped away from Staff I. It happened fast and the resident fell. It took awhile for staff to come and assist.

On 4/10/2024 at 9:10 A.M., Staff N, an agency CNA, reported working at the facility for awhile. Staff N knew to use a gait belt with any resident who requires assistance to transfer. If she did not know how a resident transferred, she would ask.

On 4/10/2024 at 9:00 A.M., Staff C, CNA reported

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 _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBROOK HEALTHCARE AND REHABILITATION CENTER	6420 COUNCIL STREET NE CEDAR RAPIDS, IA 52402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 25 working at the facility through an agency. Staff C knew she needed to use a gait belt if the resident required assistance to transfer, something she learned in CNA training. The facility Gait Belt (Use of) policy included: Purpose: To ensure the safety of the residents and staff when assisting with a transfer or ambulation a gait belt will be used. Procedure: 2. All residents who require assistance with transfers and do not require and electric lift will utilize a gait belt with all transfers. 10. The staff person will utilize safe transfer technique, moving with the resident, with the knees bent and a strong grasp on the transfer belt.	F 689		