STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165545	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windmill Manor	2332 Liberty Drive Coralville, IA 52241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44512 Based on observations, clinical record review, family and staff interviews, the facility failed to respect a resident's right to request a transfer to the emergency room for an evaluation related to blood in stool for 1 of 1 residents (Resident #7) reviewed. The facility reported a census of 81 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], for Resident #7 listed the diagnoses as pulmonary embolism, hypertension and dysphagia,. The MDS assessed the resident required moderate assistance for mobility. The assessment listed speech as clear with distinct intelligible words. The MDS listed the Brief Interview for Mental Status (BIMS) score as 15 of 15, indicating intact cognition. The Care Plan for Resident #7, dated [DATE], included a Problem related to the use of anti-coagulants medication related to a history of PE (pulmonary embolism). The plan directed staff to monitor for side effects of anticoagulant therapy such as: fever, headache, diarrhea, bruising, bleeding, nausea, vomiting, mouth ulcerations, melena (black, tarry stool associated with bleeding in the gastrointestinal tract), theatrical (blood in urine), jaundice, urticaria (hives), and rash. During an interview on [DATE] at 3:09 pm, a family member stated Resident #7 reported to her she [Resident #7] told a nurse multiple times that she wanted to go to the hospital due to the blood in her stool and the nurse replied that it was not important, not to worry about it, she was not going to go. The family member stated She Po-Pooed her. The family member stated Resident #7 reported to her no one called the family, she was up all night and miserable. The family member stated she believed that if the aides (Certified Nursing Assistants, or CNA) would not have intervened, her aunt would have died . During an interview on [DATE] at 1:45 pm, Staff B, CNA stated she worked on [DATE] from 10 pm to 6 am and provided care for Resident #7. Staff B stated Resident #7 had multiple bowel movements (BM) with blood, she felt sick and was in pain. Staff B stated Resident #7 was asking Staff A, Licensed Practical Nurse (LPN) to call her family as she wanted to go to the hospital and Staff A stated she didn't need to go to the hospital. (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	During an interview on [DATE] at 2:28 pm, Staff C, CNA stated that she provided care for Resident #7 on [DATE] starting at 10 pm. She stated the resident had multiple BM's with blood, weakness, abdomen pain and was requesting to go to the hospital. Staff C stated she knew Staff A, LPN was aware of Resident #7's request to be transported to the hospital as she went back and forth all night between the resident and the nurse with the request. During an interview on [DATE] at 8:32 am, Staff A, LPN stated she was the charge nurse on [DATE] from 6 pm to 6 am. Staff A stated that it was reported to her, that Resident #7 refused her shower, was not feeling well and had loose BM with little blood. Staff A stated at 10 pm Resident #7 wanted to go to the hospital. Staff A stated she continued to monitor Resident #7 after administering Tylenol at midnight. Staff A stated the CNA's recommended the hospital but did not remember if Resident #7 asked, She had her own phone. During an interview on [DATE] at 9:37 am Staff D, LPN stated she was the charge nurse on [DATE] at 6 am and Staff A, LPN stated Resident #7 had gone to the hospital due to pain and blood in her BM. Staff D stated if a resident requested to go to the hospital, the nurse would make an assessment of their symptoms and call the family. Staff D stated, If they request to go, they have a right to go. A review of local emergency medical services record revealed Resident transported to the hospital on [DATE] at 5:54 am. A review of hospital emergency records, dated [DATE], included an Assessment and Plan indicating bright red blood per rectum possibly due to lower GI (gastrointestinal) bleeding, cannot rule out upper GI bleeding.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44512 Based on observations, clinical record review, family and staff interviews, the facility failed to provide timely assessment and intervention for 1 of 2 residents (Resident #7) taking an anti-coagulant medication and voicing concern due to multiple episodes of diarrhea and blood in an incontinent brief. The facility reported a census of 81 residents. Findings include: The Minimum Data Set (MDS) for Resident #7, dated [DATE], list of diagnoses included pulmonary embolism, hypertension and dysphagia. The assessment revealed Resident #7 requires moderate assistant for transfers. The resident speech clear, with distinct intelligible words. The MDS included a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. The Care Plan for Resident #7 dated [DATE] that directed staff to provide the assistance of two staff for transfers, toileting and required the need for disposable briefs due to incontinence. The Progress Notes for Resident #7, documentation by Staff A, Licensed Practical Nurse (LPN) that revealed: a. [DATE] at 7:53 pm Resident refused a shower, did not feel good and denied pain. b. [DATE] 12:23 am Vital Signs: 96.5 (temperature) ,d+[DATE] (blood pressure) 76 (heart rate) 97% (blood oxygen saturation). c. [DATE] 4:53 am Resident #7 was not feeling well 97.6 (temperature) ,d+[DATE] (blood pressure) 119 (heart rate) 18 (respirations) 98% (blood oxygen saturation), 2 large loose Bowel Movements (BM), Tylenol 650 milligrams (mg) given, resident requested for pain all over. d. [DATE] at 5:35 am Resident was very weakness after 2 large loose BM, included rectal bleeding. The resident requested to go to emergency room (ER) for evaluation & treatment and was sent with records. e. [DATE] at 5:38 am Call to the Power of Attorney (POA) and updated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:45 pm, Staff B, Certified Nursing Assistant (CNA) stated she worked on [DATE] at 10 pm to 6 am and provided care for Resident #7. Staff B stated at 10:30 pm she assisted Staff C, CNA with changing Resident #7's brief due to incontinence. Staff B stated there was blood in with the BM and was reported to Staff A, LPN. Staff B stated at 12:30 am, Resident #7 initiated the call light, was incontinent of liquid BM and had a medium amount of bright red blood. Staff B stated Resident #7 was shaky, difficulty to stand with the stand lift, assisted to the bathroom, and had blood in the toilet. Staff B stated Staff C had Staff A come to the room to see the brief and results in the toilet, whom responded She is fine. Staff B stated this was not normal for Resident #7, who was asking to go to the hospital and to have family notified. Staff B stated Staff A took Resident #7's vitals and returned to the nurse's station. Staff B stated Staff A asked her to go check on Resident #7 as she didn't want to go to the hospital. Staff B stated Resident #7 was still in pain and wanted to go to the hospital but the nurse would not send her. Staff B stated this went on all night until the ambulance came at 5 am. Staff B stated that Resident #7 didn't sleep all night due to the pain. During an interview on [DATE] at 2:28 PM, Staff C, CNA stated she worked on [DATE] at 10 pm with Resident #7. Staff C stated she did not receive a report that Resident #7 was not well, she was just completing her normal rounds at start of shift, assisted Resident #7 and found bloody BM in her brief, and stated she was not well, was in pain. Staff C stated she was flushed, pale, in pain, and she had notified Staff A, LPN. Staff C stated that at midnight, Staff B asked for assistance to take Resident to the bathroom with the stand lift. Staff C stated Resident #7 was not herself, weak, large liquid BM with blood and was in pain. Staff C stated, She wanted to go to the hospital. Staff C stated she saved the brief for Staff A to view as it had bright red blood from the front to the back of the brief. Staff C stated Staff A took the vitals and gave a Tylenol but did not send Resident #7 to the hospital and stated she did not want to go to the hospital. Staff C stated She said she wanted to go to the hospital clearly. Staff C stated she had looked for the other nurse in the facility but was unable to locate her. Staff C stated she was scared for Resident #7 and insisted Staff A call for an ambulance which she did at 5 am. During an interview on [DATE] at 3:09 pm, Resident #7's niece was at bedside with her aunt who stated she told the nurse multiple times that she wanted to go to the hospital due to the blood in her stool and the nurse replied that it was not important, not to worry about it, she was not going to go. The niece stated She Po-Pooed her. The niece stated Resident #7 reported no one would call her POA, that she was up all night and miserable. The niece stated she believed that if the aids would not have intervened, her aunt would have died . During an interview on [DATE] at 11:10 am, Staff E, CNA stated she had worked on [DATE] at 2:30 pm to 10 pm and had offered Resident #7 a shower but she refused due to not feeling well. Staff E stated she had reported that to the nurse, Staff A, LPN. During an interview on [DATE] at 9:37 am Staff D, LPN stated she was the charge nurse on [DATE] at 6 am and Staff A, LPN stated Resident #7 had gone to the hospital due to pain and blood in her BM. Staff D stated if a resident requested to go to the hospital, the nurse would make an assessment of their symptoms and call the family. Staff D stated, If they request to go, they have a right to go. Staff D stated Mediprocity is the system the facility utilized to communicate with the physician and the administrator. It also had the ability to track if they had read the message. The facility provided the Metiprosity (Printed Discussion for Resident #7) that revealed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. On [DATE] at 6:46 am, Staff A, LPN sent a notification to the Administration staff and Staff F, MD regarding Resident #7's condition during the night, transferred to the hospital and called the Power of Attorney (POA). b. The Read Receipt revealed Staff F read the report on [DATE] at 7:25 am. c. The Read Receipt revealed The Administrator read the report on [DATE] at 6:57 am. The County Ambulance report dated [DATE] for Resident #7 revealed: a. Emergency Medical Services (EMS) received the call at 5:27 am. b. EMS arrived to the facility at 5:36 am. c. Dispatched for resident #7 for hemorrhage and laceration. d. CNA's reported changed Resident #7's Depends 3 times with large amounts of bright red blood. e. Resident #7 reported having diarrhea, bleeding, feeling weak, nauseous and had reported the symptoms to the nurse who stated she was fine and didn't need to go to the hospital. f. The CNA's reported they repeatedly requested the nurse to call an ambulance. g. The nurse responded to the room, handed over paperwork and left the room without giving a report on the patient. The paper work was for a different resident and EMT had to find the nurse to obtain the correct paperwork for Resident #7. h. Resident #7 was conscious, alert, and oriented to person, place, time and event. i. Resident #7's skin was pale and cool to touch. j. Resident #7's abdomen was soft and tender to palpitations (touch). k. Resident #7 reported she takes Aspirin and Xarelto blood thinners for a diagnosis of bilateral Pulmonary Emboli's (blood clot in both lungs). l. Blood pressure ,d+[DATE] hypertensive (high blood pressure) and pulse 104 tachycardic (fast heart rate). m. Resident #7 transported to the hospital at 5:54 am. The Hospital Emergency Department notes for Resident #7 revealed: a. Arrived on [DATE] via ambulance with a complaint of rectal bleeding. b. Lab values: Hemoglobin 11.0 (normal range for women ,d+[DATE] g/dl (grams per deciliter) and [NAME] Blood Count 10.9 (normal range 4,500 to 11,000 per microliter). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Hospital Admitting notes for Resident #7 revealed: a. CT (computed tomography) scan revealed a defect in the urinary bladder concern for bladder malignancy. No evidence of acute (short term) gastrointestinal bleeding. Above average stool in rectal vault and sigmoid colon suggesting constipation. b. Hemoglobin on [DATE] was 8.8 g/dl. c. A Urologist was consulted. d. Recommended Operating Room for cystoscopy (a scope used to visualize the inside of the urinary bladder) for possible left ureteral stent placement. e. The cystoscopy revealed there was no tumor, the large mass was a blood clot. f. Hemoglobin on [DATE] was 7.7 g/dl. During an interview on [DATE] at 1:10 pm The Administrator stated that Resident #7 should have been transported to the hospital when she had requested to be transported. The policy titled Emergencies dated [DATE] revealed: a. The nurse in charge will evaluate the resident's condition. b. Notify the resident's physician and follow orders. c. Call for an ambulance. d. Notify the family.