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	09/17/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to provide appropriate supervision when a staff failed to use a gait belt to ensure each resident safety during a transfer for 1 of 3 residents reviewed (Resident #1) for safety. Resident #1 fell during the transfer which resulted in a left arm and wrist fracture. The facility reported a census of 109 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated moderate cognitive impairment. The MDS further indicated that the resident received partial/moderate assistance with transfers. The clinical census for Resident #1 revealed the following: a. 7/21/25 admitted to the facility b.7/30/25 discharged from the facilityThe Care Plan initiated 7/22/25 indicated Resident #1 had a mobility deficit, utilized a front wheeled walker for transferring and required extensive assistance of 1 staff. A Progress Note dated 7/23/25 at 4:59 PM documented Resident #1 had been on the floor in the bathroom and according to the CNA the resident had been in front of the sink washing her hands and tripped backwards when she tried to turn with her walker. The CNA reported the resident dragged her down and she landed on the floor with the resident. An Incident Report (IR) dated 7/23/25 at 5:26 PM documented Resident #1 had a witnessed fall in the resident's bathroom after she had turned after washing her hands. The IR further documented a CNA had been with the resident but a gait belt had not been in place. An After Visit Summary dated 7/23/25 from a local emergency room (ER) revealed imaging tests were completed on Resident #1's left wrist and left elbow. The summary documented the reason for the visit was a fall, a diagnosis of a closed nondisplaced fracture of neck of left radius (forearm) had been determined and instructions to follow up with orthopedics for management of the fractures. The summary further documented the resident received an arm sling and left wrist splint. Review of the facility investigation of Resident #1's 7/23/25 fall revealed the resident had been sent to the ER immediately after the fall because she had been on a blood thinner. During an interview 9/16/25 at 12:25 PM, Staff A, Certified Nursing Assistant (CNA) revealed she had been in the bathroom with Resident #1 when the resident stepped back after washing her hands and then the resident tripped and fell back. Staff A stated she had been pulled down with the resident when she fell and landed next to the resident. Staff A stated she did not use a gait belt because she had looked around the room she did not see a gait belt. Staff A reported after the fall she went to get the nurse and the nurse was able to find a gait belt and she helped get the resident off the floor with a mechanical lift. Staff A acknowledged she was expected to use a gait belt when assisting residents with transfers. During an interview 9/16/25 at 12:35 PM, Staff B, Registered Nurse (RN) revealed the Staff A, CNA came and reported to her that Resident #1 was on the floor in the bathroom after she tripped after she had washed her hands. Staff B reported that Staff A had confessed to her that she had not been using a gait belt on Resident #1 prior to the fall. Review of the facility policy number 3.35 (IA) with the subject Gait Belts adopted 12/03, revealed all direct staff shall use a gait belt when transferring or ambulating residents for the protection of both staff and residents. All direct staff will have a gait belt available for use with transfers. No resident will be transferred or ambulated without the use of a gait belt, unless to do so is contraindicated and this would be identified on resident's plan of care. During an interview 9/17/25 at 9:40 AM, the Director of Nursing (DON) revealed it is an expectation staff utilize a gait belt per policy if a resident requires assistance with transfers. Review of the personnel file for Staff A, CNA revealed she completed the new employment checklist for a CNA on 9/13/24. The checklist included use of a gait belt. Review of in-service education revealed use of gait belt training had been completed on 9/30/24 and 7/16/25. Staff A, CNA signed that she had been present during both in-service training sessions.