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	04/09/2026

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

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, resident and staff interviews, and facility policy review, the facility failed to serve food at a safe, preferred temperature and palatable. The facility reported a census of 111 residents. Findings include: 1. During the observation of the noon meal on 04/07/2026 at 12:05 PM, Staff N, took the temperature of the pork entree with a result of 171 degrees Fahrenheit (F). The pureed pork had a temperature of 166 F. At 1:35 PM, Staff O, [NAME] took the temperatures of a test tray for the State Agency. The pureed pork had a temperature of 113 F, and the pork entrée had a temperature of 135 F. The pork entrée lukewarm upon the taste test. 2. The Minimum Data Set (MDS) assessment tool, dated 3/10/26, listed Resident #13's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. During an interview on 4/6/26 at 11:52 AM, Resident #13 stated she did not get her lunch serviced until after 1:00 PM and it was cold. 3. Review of the MDS assessment for Resident #86, dated 3/10/26, revealed a BIMS score of 12 out of 15, which indicated a moderate cognitive impairment. The assessment identified the resident had diagnoses of dysphagia (difficulty swallowing and vascular dementia, severe, with psychotic disturbances. On 4/6/26 at 11:30 AM, during an interview, Resident #86 reported the food was over-cooked with no flavor in the pureed form. The resident reported she usually ate in her room. During an observation on 4/7/26 at 1:08 PM, Resident #86 received her lunch. During an interview at 3:00 PM, Resident #86 reported her lunch was overcooked and cold. During an interview on 04/07/2026 at 12:03 PM, the Dietary Manager informed no food temperature entered in the log book for April 2026. The Dietary Manager stated this would be resolved immediately. The Dietary Manager stated hot foods should be served at a temperature between 145 F and 165 F. During an interview on 04/09/2026 at 9:04 AM, the Dietary Manager (DM) stated there is a lot of work to do in the kitchen. The DM stated the day of the meal observation the service was too slow and unorganized. The DM stated the process for logging food temperatures and dishwasher temperatures needs to change. The DM stated the other areas that need to improve are cleanliness, staff training and consistency. (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Meal Service in Dining Room or Other Area, dated 08/22 directed: It is the policy of this facility to serve meals to residents by following procedures that are in compliance with state and federal regulations. Dining Services staff will deliver food to all dining rooms in a hot cart. Hot food will be placed in the steamtable and covered until ready to serve. Staff will record the temperature of all hot food .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews and policy review the facility failed to ensure kitchen equipment and floors are maintained in a clean and sanitary manner, open food items dated, and expired food items discarded. The facility reported a census of 111 residents.Findings include:1. During a continuous observation on 4/6/26 starting at 10:40 AM, and ending at 11:09 AM the following noted: a. In the dry pantry – a wet, brown substance on the floor, and the floor felt sticky. The following opened items found in the dry pantry with no date labeled to indicate when opened - a low-calorie punch drink; a container of an unidentified white powerlike substance, and a bag of crispy fried onions. b. The main refrigerator temperature log blank from April 1 -4, 2026. A container of soy sauce opened with no open date indicated, and an outdated container of a pureed dessert dated 3/29/26 found in the refrigerator. c. The dishwasher logs for temperature and sanitizer yet to be completed for the April 2026. d. The kitchen floor noted to be sticky and have visible crumbs. e. The grill not cleaned of particles from breakfast, and a dirty grill scraper stored above the grill. f. The microwave found with food particles on the inside roof and a brown substance on bottom. g. The heat cart had a crusty substance on the outside and was sticky on the inside. h. Visible dry food and debris was observed on the bottom of shelving throughout the kitchen. No food temperature logs were completed for the month of April 2026. During an interview on 04/06/2026 at 10:40 AM Staff B, Dietary Manager, stated that it was her first day here and the kitchen hasn't had a manager in a month and a half. At 10:52 AM Staff B noticed and acknowledged an open container of bread crumbs that was expired and an open bag of pasta that had no date on it. Staff B removed both and disposed of them. At 11:06 AM Staff B showed and acknowledged the current cleaning schedule in which none of the cleaning tasks were signed off for the month. Review of the facility policy titled, Sanitation and Safety, dated 9/2010 revealed a Purpose statement which declared To prevent food contamination and food poisoning. To prepare food under safe and sanitary conditions. All daily and scheduled cleaning will be maintained.

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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. Based on observation, interview, and policy review the facility failed to ensure laundry was processed and transported in a safe and sanitary manner in a hallway with 31 residents and in the laundry room. The facility staff also failed to wear appropriate protective equipment when soiled laundry was sorted. The facility reported a census of 111 residents.Findings include: During a continuous observation that started at 1:30 PM on 04/07/2026, Staff A, Laundry, delivered clean laundry residents in hall 100. Staff A used a laundry cart covered with a bed sheet. During the transport, three pieces of clothes (blue pants, purple shirt and a red shirt) hung outside of the cart and touched the handrail along the hallway. Staff A removed the cover sheet, bundled it up and placed it on top of the cart. Staff A gathered clean clothes on hangers and while taking them into a resident's room they brushed up against her scrub top. At 1:37 PM and again at 1:39 PM, Staff A removed dirty clothing from a resident room and placed them in the cart with the clean clothing. At 1:42 PM, Staff A took dirty clothing out of a room under Enhanced Barrier Precautions and placed them on the top of clean clothing in the cart. The clean clothing card uncovered during the continues observation, which ended at 2:05 PM. During an interview on 04/09/2026 at 9:26 AM, Staff A, Laundry staff stated the clean laundry cart should be covered at all times in the hallways. Staff A explained a bath sheet is generally used to cover the cart. Staff A stated sometimes she did not cover the cart because she got busy and it took too much time. 2. During an observation on 4/8/2026 at 9:25AM, Staff E, Laundry staff sorted laundry wearing gloves but no gown. During an interview on 4/8/2026 at 9:30 AM, Staff C, Housekeeping and Laundry Supervisor, stated staff should wear gloves and gowns (Personal Protective Equipment or PPE) when they sorted laundry. During an interview on 4/9/2026 at 9:11 AM, Staff E, Laundry staff stated she should have been wearing a gown and gloves when sorting laundry. Review of the facility policy, titled Laundry and Linens Department Policy, dated 03/2024 directed the Laundry Supervisor ensured the department complied with established standards. A review of the facility policy Infection Control, dated 12/17/2019 directed the facility followed standard precautions which included hand hygiene, proper use of personal protective equipment, and care of laundry.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and staff interview, the facility failed to implement their policy to prohibit and report allegations of abuse of a resident for 1 of 1 resident (Resident #72) reviewed for abuse. The facility reported a census of 111 residents.Findings include:The Minimum Data Set (MDS), dated [DATE], listed diagnoses for Resident #72 which included diabetes, non-Alzheimer's dementia, and weakness. The MDS listed his Brief Interview for Mental Status (BIMS) score as 8 out of 15, indicating moderately impaired cognition. Review of the electronic health record (EHR) revealed the following:a. A 5/17/25 Nursing Note entered at 3:34 PM, written by Staff H Registered Nurse (RN): During a visit, the resident began yelling at the visitor. In response, the visitor became upset, stepped on the resident's foot, and loudly told him to shut up. The nurse chose not to intervene at this time to avoid escalating the situation but would like to formally report the visitor inappropriate behavior toward the resident. b. A 2/14/26 Nursing Note entered at 6:07 PM: Nurse observed [relationship to resident redacted] getting aggressive with the resident due refusing care. Educated that if she is not able to keep her composure then she is able to leave the room during cares. On 4/8/26, the Assistant Administrator provided an untitled, undated soft file regarding the 5/17/25 incident. A review of the file revealed a document which stated the visitor stated she did not purposely step on the resident's foot. Staff H stated he did not intervene in the situation because he was unsure if it was intentional. The document stated staff told the visitor that if she became anxious or frustrated, she should notify staff and ask them to assist with de-escalating behaviors. The facility educated the nurse to call the Administrator and intervene if the resident had any concerns .The facility unable to provide additional information regarding an investigation or report to adult protective services related to the incident on 5/17/25 or 2/14/26. During an interview on 4/8/26 at 8:31 AM, the Director of Nursing (DON) stated she remembered something about the visitor grabbing the resident or something to that extent. She stated she could not think of anything physical that occurred. She stated if there was a physical altercation with a visitor involved, they would report this to adult protective services She stated she was not aware that the visitor stepped on the resident's footOn 4/8/26 at 9:16 AM, via phone interview, Staff H, RN stated with regard to the 5/17/25 incident, the resident's visitor was frustrated with him when she stepped on his foot. He stated he could not be sure it was on purpose but she was angry at the time she carried out the action. During an interview on 4/8/26 at 11:35 AM, the Assistant Administrator stated if there was an allegation of physical abuse between a visitor and a resident, the facility would report this to adult protective services. During an interview on 4/8/26 at 12:40 PM, the Administrator stated if there was an allegation of abuse between a visitor and a resident, the facility would follow their abuse policy and investigate. Review of the facility policy titled Abuse Prohibition and Reporting, revised 11/28/19, revealed Policy statement which declared: The facility actively prohibits resident abuse including. The Purpose statement declared: To protect resident from any kind of abuse. The Procedure section directed: Initial steps and reports of alleged abuse or neglect -1. Facility employee or agent who becomes aware of alleged abuse or neglect of a resident should immediately report the matter to the facility Administrator.2. If the incident involves alleged abuse or neglect, the Administrator shall provide the Iowa Department of Inspection and Appeals with initiate notice of the alleged abuse or neglect.The policy did not specifically address visitor to resident allegations of abuse.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interview, the facility failed to revise a care plan to ensure resident safety with a visitor after allegations of abuse had been identified for 1 of 1 residents (Resident #72) reviewed for care plans. The facility reported a census of 111 residents.Findings include:The Minimum Data Set (MDS), dated [DATE], listed diagnoses for Resident #72 which included diabetes, non-Alzheimer's dementia, and weakness. The MDS listed his Brief Interview for Mental Status (BIMS) score as 8 out of 15, indicating moderately impaired cognition. Review of Resident #72 Care Plan revealed no Problem area to address safety with visitors related to past allegations of abuse. Review of the electronic health record (EHR) revealed the following:a. A 5/17/25 Nursing Note entered at 3:34 PM, written by Staff H Registered Nurse (RN): During a visit, the resident began yelling at the visitor. In response, the visitor became upset, stepped on the resident's foot, and loudly told him to shut up. The nurse chose not to intervene at this time to avoid escalating the situation but would like to formally report the visitor inappropriate behavior toward the resident. b. A 2/14/26 Nursing Note entered at 6:07 PM: Nurse observed visitor getting aggressive with the resident due refusing care. Educated that if she is not able to keep her composure then she is able to leave the room during cares.During an interview on 4/8/26 at 8:05 AM, Staff G Social Worker stated the visitor identified in the 5/17/25 and 2/14/26 Nursing Notes was very involved in Resident #72's care. Staff G stated after one report to adult protective services, there had been a care conference with the visitor. When queried as to what interventions the facility implemented regarding the resident's safety and the visitor Staff G stated she wasn't sure.Review of the facility policy titled Care Plan Policy, revised 6/1/22, stated the comprehensive person-centered care plan would include the resident's mental and psychosocial needs and directed to incorporate any changes into the care plan.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, staff interviews, and facility policy review the facility failed to properly store and secure resident safety and accessibility of a medication cart by leaving it unlocked and accessible to residents during medication pass near the main dining room. The facility identified a census of 111 residents. Findings include:During a continuous observation on 04/06/2026 started at 4:15 PM, Staff J, Certified Medication Aide (CMA), positioned the medication cart in the living room approximately 20 feet from the dining room. a. At 4:18 PM, Staff J, CMA walked away from the cart to administer medication and left all eight drawers unlocked, which included the first lock to the narcotics.b. At 4:40 PM and again at 4:50 PM, Staff J, CMA walked away from the cart to administer medication to a resident in the dining room. The cart remained unlocked. During an interview on 4/6/26 at 4:55 PM, Staff J, CMA stated she typically locked the medication cart when she walked away. She explained that since she went from the living room across to the dining room and the cart remained in her sight, she did not lock it. Staff J stated that when administering medications to residents in the dining room she would constantly have to lock and unlock the cart, but since the dining room was close, she did not lock it between residents.During an interview on 04/07/2026 at 8:24 AM, Staff K, Licensed Practical Nurse (LPN), stated the medication cart should be locked at all times. Staff K added that this is true even if a nurse administered medications without leaving the room. Staff K explained that many residents in the facility wander. Staff K stated that if she positioned the cart in the living room and administered medications to residents in the dining room the cart would be locked. During an interview on 04/08/2026 at 4:20 PM, the Director of Nursing and Administrator stated that medication carts must be locked at all times and a staff member should never walk away and leave a cart unlocked.Review of the facility policy titled, Pharmaceutical Procedure revised 01/05/2023, Section V Care and Storage of Medications subsection B directed:Resident's medications shall be properly labeled and stored at or near the nurses' station in: 3. one of more locked mobile medication carts.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, clinical record review, resident interview, family and staff interviews, the facility failed to ensure the resident received food in a consistency based on physician orders for 1 of 2 residents (Resident #86) reviewed for therapeutic diet. The facility reported a census of 111 residents. Findings include: Review of the Minimum Data Set (MDS) assessment for Resident #86, dated 3/10/26, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated a moderate cognitive impairment. The assessment identified the resident had diagnoses of dysphagia (difficulty swallowing) and vascular dementia, severe, with psychotic disturbances. Review of the Physician Order Report, dated 4/1/26 to 4/30/26, revealed an order, dated 3/30/26 for regular diet when supervised and pureed diet when unsupervised. Review of the Care Plan for Resident #86, dated 3/20/26, revealed the resident received a regular diet when eating supervised in the dining room, and received a pureed diet when eating unsupervised in her room. During an interview on 4/6/26 at 11:30 AM, Resident #86 reported the pureed food was over-cooked with no flavor. The resident reported she usually ate in her room. During an observation on 4/7/26 at 1:08 PM, the Speech Therapist brought Resident #86's lunch to the resident's room. The resident received pot roast in a soft mixed form (potatoes, gravy, meat all mixed together), sweet potatoes in a mashed form, pureed cauliflower and broccoli mix and a pureed fruit cobbler dessert. The Speech Therapist stayed in the room while the resident ate her lunch. On 4/7/26 at 3:00 PM, during an interview, Resident #86 stated it upset her to be served pureed food for lunch and she did not want pureed food.During an interview on 4/07/2026 at 4:55 PM, a family member of Resident #86' stated the resident hated the pureed diet. The family member stated when the Speech Therapist sat with the resident, the resident should then get regular textured food. The family member explained they understood if Resident #86 did not agree to have a staff member sit with her for every meal, or sit by the nurse's station, then the resident would get pureed food.On 4/8/26 at 2:19 PM, during an interview, the Speech Therapist/Rehabilitation Director reported she was the only staff the resident would let supervise her while the resident ate in her room. The Speech Therapist reported she tried to supervise the resident two to three times per week. When asked why the Speech Therapist brought the resident pureed food on 4/7/6 during the supervised lunch, the Speech Therapist responded she asked dietary for a regular diet, and they gave her the pureed food. During an interview on 4/8/26 at 2:57 PM, the Director of Nursing (DON), reported there was a care conference for Resident #86 on 4/3/26 to address the resident being upset about her pureed diet. The DON stated the resident coughed with regular consistency food, and it was not safe. The DON explained the resident refused to eat in the dining room, or near the nurse's station or have anyone but the Speech Therapist supervise her meals. The DON stated Resident #86 had an order for pureed food if she was not supervised during the meal.