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	12/30/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review and staff interviews, the facility failed to ensure medications available for administration as ordered for 1 of 3 residents (Resident #3). Resident #3 missed a total of four doses of medications due to two medications not be available in the facility. The facility reported a census of 105 residents. Findings include: Review of the Minimum Data Set (MDS) assessment, dated 11/05/25, revealed Resident #3 admitted to the facility on [DATE] and had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. The list of diagnoses included lung transplant status and adult failure to thrive. Review of the Care Plan, initiated on 10/30/25, revealed a Focus area for Resident #3 admission after hospitalization for adult failure to thrive, severe protein calorie malnutrition, and bilateral lung transplant requiring continued antirejection medications. The intervention instructed staff to administer antirejection medications per doctor orders. Review of the Medications Administration History, dated between 10/29/25 and 11/21/25, revealed the following medication orders: Azathioprine 50 milligram (mg) tablet to be administered daily at bedtime. Start date: 10/29/25 for diagnosis of lung transplant status. Tacrolimus 2mg capsule to be administered twice per day. Start date: 10/29/25 for a diagnosis of lung transplant status. Tacrolimus 0.5mg capsule to be given with the 2mg dose, to equal 2.5mg, every evening. Start date: 10/29/25 for a diagnosis of lung transplant status. Review of the Medications Administration History, dated between 10/29/25 and 11/21/25, revealed the following medication doses coded as, Not Administered: Drug/Item unavailable: On 11/12/25 at 7:13 PM, Azathioprine 50mg tablet coded as Not Administered: Drug/Item unavailable. On 11/13/25 at 7:54 PM, Azathioprine 50mg tablet coded as Not Administered: Drug/Item unavailable.On 11/13/25 at 7:54 PM, Tacrolimus 2mg capsule coded as Not Administered: Drug/Item unavailable. On 11/14/25 at 7:57 PM, Tacrolimus 2mg capsule coded as Not Administered: Drug/Item unavailable. Review of a nursing progress note, dated 11/12/25 at 1:23 PM, documented that the nurse called and spoke with [name redacted] at [facility redacted] lung transplant coordinator. The order for Tacrolimus is to be 2mg in the AM and 2.5mg in the PM. [Name redacted] stated to continue this order. Resident #3 will have labs done Monday. Review of a provider visit note, dated 11/13/25 at 10:40 AM, documented that Resident #3's Tacrolimus dosing was verified per [facility redacted] lung transplant coordinator. The provider documented that the plan for lung transplant status included continuing the immunosuppression regimen of Tacrolimus and Azathioprine. Review of Resident #3's Electronic Health Records (EHR), dated between 11/12/25 and 11/20/25, lacked documentation of attempts to obtain the unavailable medications and lacked documentation of physician notification to report that medications were not administered as ordered. Review of a Late Entry nursing note, recorded on 11/21/25 at 3:08 PM, dated for 11/14/25 at 3:06 PM, revealed that the nurse was alerted by medication aide that Resident #3's Tacrolimus 1mg is not available. This nurse called the pharmacy and spoke with the pharmacist who stated that he will have medication sent from a local pharmacy STAT (immediately) so that resident will not miss another dose. Review of a Late Entry nursing note, recorded on 12/04/25 at 3:47 PM, dated for 11/21/25 at 3:17 PM, revealed that the Assistant Director of Nursing (ADON) called the liver transplant team and talked with the doctor. The doctor was informed that the resident missed two doses of tacrolimus. The doctor reviewed the resident's labs from her previous visit and no new orders were received at this time. Review of pharmacy delivery requisitions revealed the following dates and amounts of Azathioprine and Tacrolimus delivered to the facility for Resident #3: 1. On 10/29/25:Azathioprine 50 mg tablets, 14 tablets delivered and received (14 day supply). Tacrolimus 0.5mg capsules, 14 capsules delivered and received (14 day supply). Tacrolimus 1mg capsules, 56 capsules delivered and received (14 day supply). 2. On 11/10/25: Tacrolimus 0.5mg capsules, 14 capsules delivered and received. 3. On 11/13/25: Azathioprine 50mg tablets, 14 tablets delivered and received.4. On 11/14/25: Tacrolimus 1mg capsules, 56 capsules delivered and received.5. On 11/20/25: Tacrolimus 0.5mg capsules, 14 capsules delivered and received. During an interview on 12/30/25 at 9:45 AM, Staff B, Registered Nurse (RN), confirmed having worked the morning (6:00 AM to 2:00 PM) shift on 11/14/25 and recalled that the Medication Aide reported being unable to locate Resident #3's Tacrolimus medication. Staff B stated that she looked at Resident #3's medication records and identified that the Tacrolimus had not been administered the previous evening (11/13/25), then called the pharmacy for a STAT delivery of the medication to be given for 11/14/25 evening dose. Staff B reported that the pharmacy told her the medication would be delivered from a