DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0199	A. BUILDING: _____ B. WING _____	C 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR MANOR INDIANOLA	**608 SOUTH 15TH STREET INDIANOLA, IA 50125**

(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) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 23 Number of tenants with cognitive impairment: 17 Total census: 40 The following regulatory insufficiencies were cited during the investigation of Complaint #127912-C, Complaint #128123-C and the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia.	A 000	See attached POC 10/22/25	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to follow the Night Check policy for 1 of 4 discharged tenants reviewed (Tenant C4). Findings follow: Record review on 8/20/25 revealed the following entries from the program nurse: - On 6/6/25 it was noted Tenant C4 had a five pound weight loss from April to May. The PCP was notified. Staff were to monitor her weight weekly for four weeks and report back to the PCP.	A 150		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 150	Continued From page 2 completed checks on Tenant C4 when she told others she did not complete the checks on an hourly basis. The program had a Night Checks policy to ensure adequate monitoring would occur to meet the needs of tenants 24 hours a day, seven days a week. When making rounds, the night associates should listen at each door and quietly monitor each tenant. Some tenants would want associates to visually check on them. For tenants who were ill, the night associates should open their doors to see if they needed anything. During an interview with the Resident Care Director on 8/20/25 at 8:40 AM she reported Tenant C4 had a respiratory infection at the time of her death. She had recently started on a new antibiotic and was not feeling well. The Resident Care Director recalled the tenant telling her the day before her death she was not feeling well. The employees should have been checking on Tenant C4 at least every hour. Staff D had a pen light and knew she should go into each room and check to ensure tenants were breathing every hour. Staff D told her she was not checking on tenants each hour as she was unable to be everywhere all at once.	A 150		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be	A 285		

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A 285	Continued From page 3 administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to administer medication as prescribed to 2 of 5 current tenants reviewed (Tenant #4 and Tenant #5). Findings follow: 1) Record review on 8/19/25 of Nurse's notes for Tenant #4 revealed he went to the hospital on 5/30/25 after experiencing chest pains and was admitted due to having a heart attack. The Resident Care Director visited him in the hospital on 6/4/25 noting he was ready for discharge. She was informed Tenant #4's Primary Care Provider (PCP) discontinued his Prevastatin and 5mg. dose of Lisinopril and updated the Medication Administration Record (MAR). On 6/6/25, the program received a fax with post-hospitalization changes to Resident #4's medication list which included the addition of: Aspirin 81 mg., Atorvastatin 40 mg., Clopidogrel 75 mg., Lisinopril 10 mg., Nitroglycerin 0.4 mg. sublingual tablet and Spironolactone 25 mg. His PCP directed the Resident Care Director to administer medication per the provided list. The Resident Care Director faxed the list to the pharmacy on 6/6/25. A review of Tenant #4's June MAR revealed these changes were not made as directed. He did not receive these medications on 6/6/25 - 6/9/25. Tenant #4 met with his cardiologist on 6/10/25 at which time the Lisinopril,	A 285		

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A 285	Continued From page 4 Spironolactone and Aspirin were discontinued by the doctor. The program started administering the Atorvastatin and Clopidogrel on 6/10/25. Tenant #4 also did not receive two other routine medications in June, 2025: Omeprazole and Duloxetine from 6/5/25 - 6/9/25 and Alpha Lipoic from 6/10/25 - 6/16/25. During an interview with the Executive Director on 8/20/25 at 1:00 PM she reported there were issues with getting Resident #4's prescriptions filled upon his return from the hospital after his heart attack as they were sent to the wrong pharmacy. The Executive Director confirmed there was no documentation in the record about this. She stated he missed the Omeprazole, Duloxetine and Alpha Lipoic because the program was waiting for new prescriptions from the PCP. 2) Record review of incident reports on 8/20/25 revealed the following for Tenant #5: - Staff documented they administered Pantoprazole to Tenant #5 on 6/1/25 - 6/4/25, but the pills could not have been given to the tenant as the medication pack was in the nurse's office. - Staff did not administer Gabapentin 100mg. to Tenant #5 on 7/6/25. During an exit meeting on 8/20/25 with the Executive Director and Resident Care Director they confirmed program staff failed to administer medication as directed.	A 285		
A 370	481-69.26(3)a Service Plans 69.26(3) When a tenant needs personal care or	A 370		

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A 370	Continued From page 5 health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure service plans were updated to address the changing needs of 2 of 5 current tenants reviewed (Tenant #1 and Tenant #5) and 1 of 4 discharged tenants reviewed (Tenant C1). Findings follow: 1) Tenant #1 had a service plan dated 6/10/25. The service plan identified she had a right occipital lobe stroke on 5/5/25 and experienced a cognitive decline resulting in her being alert and oriented only to self. Without direction or guidance, she could become easily distracted or confused. The service plan noted Tenant #1 could become forgetful and had wandering concerns. She was noted to be continent of bowel and bladder but could have urge incontinence. She was independent with managing her incontinence needs. A review of Nurse's notes revealed the following entries: - The nurse sent a fax to Tenant #1's Primary Care Provider (PCP) on 7/17/25 to report she was experiencing hallucinations and had been very aggressive toward staff and other tenants. She was wandering into others' apartments,	A 370		

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A 370	Continued From page 6	A 370		

screaming at them and refusing to leave their rooms. The nurse asked if they could have medication to help with the agitation. The PCP prescribed Risperidone 0.25 mg. daily for severe agitation.

- She was sent out via 911 on 7/24/25 for combative behaviors and admitted to the hospital. The nurse went to the hospital on 7/29/25 and found Tenant #1 was medically stable but still behaviorally unstable. She needed both physical restraints, chemical sedation and 1:1 attention for safety at the hospital. The nurse spoke with the unit manager and let them know Tenant #1 needed to be behaviorally stable before she could return to the program. She returned on 8/1/25.

During an interview with Staff A on 8/19/25 at 3:10 PM she stated Tenant #1 often became difficult to direct in the evening. She had to be watched constantly after supper to ensure she would not harm others. Tenant #1 would enter others' apartments to gather their things because she thought these items belonged to her. Staff A walked into Tenant #1's apartment once and found her urinating in one of her dresser drawers. The tenant emptied her belongings out of the drawer so she could use it like a toilet. She heard from her co-workers Tenant #1 urinated in other places such as the floor and the closet.

Staff B was interviewed on 8/19/25 at 10:40 AM and stated if staff did not watch Tenant #1 all of the time she would enter other tenants' apartments. She might also rip things apart, attempt to leave the building and had even eaten salt from the shaker. At night she would get aggressive with staff by throwing things at them.

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A 370	Continued From page 7 Tenant #1 had urinated in her air conditioning unit, her dresser, on the floor and in the towel room. Tenant #1's service plan was not updated to address her wandering into others' apartments and taking their belongings, destructive behaviors or toileting in inappropriate places. 2) Tenant #5 had a service plan dated 5/22/25 which noted she was independent in her mobility with the use of a walker. She might need reminders from staff to use her walker. Due to osteoarthritis, Tenant #5 might use a wheelchair for longer distances. Her goal was to maintain her current level of ambulation. Staff were to report to the nurse if Tenant #5 was having difficulty walking or experiencing weakness. A review of notes from the primary care provider (PCP) revealed the following: - Tenant #5 was seen on 7/16/25 by the PCP for an acute follow-up of pain management. She was seen in bed and seemed to be in a good mood. Staff reported increasing pain with repositioning and cares which was improved with medication. - The PCP provided an order for a hospice evaluation for Tenant #5. - The PCP met with Tenant #5 for an acute admission to hospice level of care due to degenerative brain disease. She had a decline in appetite with weight fluctuation. Tenant #5 was experiencing an increase of pain with cares and mobility, spending most of her day in bed.	A 370		

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A 370	Continued From page 8 - Tenant #5 met with her PCP on 8/6/25 for an acute visit due to concerns of her continued bed-bound status. She "is with continued desire to remain in bed". Tenant #5 was with continued resistance with cares and resistance to assistance with getting up. The PCP noted Tenant #5 may be reaching a higher level of care. Staff A was interviewed on 8/19/25 at 3:10 PM and reported Tenant #5 was unable to walk. As far as she knew, Tenant #5 had not left her bed for the past 2-3 weeks. An interview was conducted with Staff B on 8/19/25 at 10:40 AM and she reported Tenant #5 had been bed-bound for about a month. On 8/19/25 at 3:45 PM Staff C reported she did not think Tenant #5 had left her bed in about a month. She received toileting assistance in bed, which usually required two staff. Tenant #5's service plan was not updated to reflect she had not left her bed for an extended period of time and providing staff direction for meeting her needs. 3) Tenant C1 had a service plan dated 5/2/25. The service plan made no reference to Tenant C1 having a skin tear, blood clot or the discontinuation of the majority of medical care to receive what is known as "comfort care" as she neared the end of her life. A review of Nurse's Notes and information from Tenant C1's PCP revealed the following: - A nursing note on 6/4/25 identified Tenant C1 had a skin tear to her left calf. Her PCP ordered	A 370		

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A 370	Continued From page 9 daily dressing changes. - Tenant C1's PCP met with her on 6/4/25 for acute concerns of changes in color and temperature of the left leg. The PCP noted Tenant C1 had darkened purple discoloration, a cool foot and a warm upper left shin. She was in pain when placing pressure on her foot. There was a wound present to her shin, ecchymotic bruising with a skin tear to the proximal/lateral knee. - The dressing change to the left leg was discontinued on 6/16/25. The wound was to remain open to the air. - The program had a care conference with Tenant C1's daughter/power-of-attorney on 6/17/25. A decision was made to begin comfort cares and end non-comfort medication. Tenant C1's service plan was not updated to reflect the changes to her left leg or the changes to her care as she reached the end of her life. During an exit meeting on 8/20/25 at 1:30 PM the Executive Director and Resident Care Director confirmed the program failed to update tenants' service plans as their needs changed.	A 370		

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A 285	Continued From page 3 administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to administer medication as prescribed to 2 of 5 current tenants reviewed (Tenant #4 and Tenant #5). Findings follow: 1) Record review on 8/19/25 of Nurse's notes for Tenant #4 revealed he went to the hospital on 5/30/25 after experiencing chest pains and was admitted due to having a heart attack. The Resident Care Director visited him in the hospital on 6/4/25 noting he was ready for discharge. She was informed Tenant #4's Primary Care Provider (PCP) discontinued his Prevastatin and 5mg. dose of Lisinopril and updated the Medication Administration Record (MAR). On 6/6/25, the program received a fax with post-hospitalization changes to Resident #4's medication list which included the addition of: Aspirin 81 mg., Atorvastatin 40 mg., Clopidogrel 75 mg., Lisinopril 10 mg., Nitroglycerin 0.4 mg. sublingual tablet and Spironolactone 25 mg. His PCP directed the Resident Care Director to administer medication per the provided list. The Resident Care Director faxed the list to the pharmacy on 6/6/25. A review of Tenant #4's June MAR revealed these changes were not made as directed. He did not receive these medications on 6/6/25 - 6/9/25. Tenant #4 met with his cardiologist on 6/10/25 at which time the Lisinopril,	A 285	481-67.5(2)f(4) Medications RN will review new medication orders upon return to Windsor Manor after any extended stay at another facility. 481-67.5(2)f(4) Medications RN or delegated designee will update MAR with any new medication orders on the day that new orders are recieved. 481-67.5(2)f(4) Medications RN or designee will contact pharmacy and/or physician as indicated if medications are not delivered from pharmacy within 24 hours	9/24/25 9/24/25 9/24/25

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	S0199	A. BUILDING: _____ B. WING _____	C 08/20/2025

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A 285	Continued From page 4 Spironolactone and Aspirin were discontinued by the doctor. The program started administering the Atorvastatin and Clopidogrel on 6/10/25. Tenant #4 also did not receive two other routine medications in June, 2025: Omeprazole and Duloxetine from 6/5/25 - 6/9/25 and Alpha Lipoic from 6/10/25 - 6/16/25. During an interview with the Executive Director on 8/20/25 at 1:00 PM she reported there were issues with getting Resident #4's prescriptions filled upon his return from the hospital after his heart attack as they were sent to the wrong pharmacy. The Executive Director confirmed there was no documentation in the record about this. She stated he missed the Omeprazole, Duloxetine and Alpha Lipoic because the program was waiting for new prescriptions from the PCP. 2) Record review of incident reports on 8/20/25 revealed the following for Tenant #5: - Staff documented they administered Pantoprazole to Tenant #5 on 6/1/25 - 6/4/25, but the pills could not have been given to the tenant as the medication pack was in the nurse's office. - Staff did not administer Gabapentin 100mg. to Tenant #5 on 7/6/25. During an exit meeting on 8/20/25 with the Executive Director and Resident Care Director they confirmed program staff failed to administer medication as directed.	A 285	481-67.5(2)f(4) Medications Medication administration policy training will be completed with all staff who administer medications. 481-67.5(2)f(4) Medications RN will review all MAR's comparing to current physician orders to ensure accuracy. 481-67.5(2)f(4) Medications RN will audit MAR's weekly x 1 month to ensure MAR's are current and accurate. 481-67.5(2)f(4) Medications RN will audit MAR's routinely, no less than monthly, indefinitely 481-67.5(2)f(4) Medications Resignation accepted from Resident Care Director and effective 9/26/25 481-67.5(2)f(4)Medications New Intirim Resident Care Director (RN) hired 9/29/25	10/16/25 09//25 10/22/25 10/22/25 9/26/25 9/29/25
A 370	481-69.26(3)a Service Plans 69.26(3) When a tenant needs personal care or	A 370		

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A 370	Continued From page 5 health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure service plans were updated to address the changing needs of 2 of 5 current tenants reviewed (Tenant #1 and Tenant #5) and 1 of 4 discharged tenants reviewed (Tenant C1). Findings follow: 1) Tenant #1 had a service plan dated 6/10/25. The service plan identified she had a right occipital lobe stroke on 5/5/25 and experienced a cognitive decline resulting in her being alert and oriented only to self. Without direction or guidance, she could become easily distracted or confused. The service plan noted Tenant #1 could become forgetful and had wandering concerns. She was noted to be continent of bowel and bladder but could have urge incontinence. She was independent with managing her incontinence needs. A review of Nurse's notes revealed the following entries: - The nurse sent a fax to Tenant #1's Primary Care Provider (PCP) on 7/17/25 to report she was experiencing hallucinations and had been very aggressive toward staff and other tenants. She was wandering into others' apartments,	A 370	481-67.5(2)f(4)Medications RD will audit MAR's, medications & orders routinely every 3-6 months to ensure accuracy 481-69.26(3)a Service Plans RN will be trained on indicators that prompt an update to a service plan. 481-69.26(3)a Service Plans RN will be trained on Service plan policy and procedure, specifically focusing on adding interventions for behaviors such as aggression, wandering, changes in mobility function, and end of life changes. 481-69.2(3)a Service Plans RN will audit all resident service plans to ensure plans correctly identify resident needs/requests and directives are clear to staff.	10/22/25 10/17/25 10/17/25 10/13/25

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A 370	Continued From page 6 screaming at them and refusing to leave their rooms. The nurse asked if they could have medication to help with the agitation. The PCP prescribed Risperidone 0.25 mg. daily for severe agitation. - She was sent out via 911 on 7/24/25 for combative behaviors and admitted to the hospital. The nurse went to the hospital on 7/29/25 and found Tenant #1 was medically stable but still behaviorally unstable. She needed both physical restraints, chemical sedation and 1:1 attention for safety at the hospital. The nurse spoke with the unit manager and let them know Tenant #1 needed to be behaviorally stable before she could return to the program. She returned on 8/1/25. During an interview with Staff A on 8/19/25 at 3:10 PM she stated Tenant #1 often became difficult to direct in the evening. She had to be watched constantly after supper to ensure she would not harm others. Tenant #1 would enter others' apartments to gather their things because she thought these items belonged to her. Staff A walked into Tenant #1's apartment once and found her urinating in one of her dresser drawers. The tenant emptied her belongings out of the drawer so she could use it like a toilet. She heard from her co-workers Tenant #1 urinated in other places such as the floor and the closet. Staff B was interviewed on 8/19/25 at 10:40 AM and stated if staff did not watch Tenant #1 all of the time she would enter other tenants' apartments. She might also rip things apart, attempt to leave the building and had even eaten salt from the shaker. At night she would get aggressive with staff by throwing things at them.	A 370	481-69.2 (3)a Service Plans RN will review service plans within 30 days of move-in, a minimum of every 90 days, annually and with any change of condition. 481-69.2 (3) Service Plans RD will audit service plans at random every 3-6 months to ensure accuracy	10/17/25 10/22/25

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A 370	Continued From page 7 Tenant #1 had urinated in her air conditioning unit, her dresser, on the floor and in the towel room. Tenant #1's service plan was not updated to address her wandering into others' apartments and taking their belongings, destructive behaviors or toileting in inappropriate places. 2) Tenant #5 had a service plan dated 5/22/25 which noted she was independent in her mobility with the use of a walker. She might need reminders from staff to use her walker. Due to osteoarthritis, Tenant #5 might use a wheelchair for longer distances. Her goal was to maintain her current level of ambulation. Staff were to report to the nurse if Tenant #5 was having difficulty walking or experiencing weakness. A review of notes from the primary care provider (PCP) revealed the following: - Tenant #5 was seen on 7/16/25 by the PCP for an acute follow-up of pain management. She was seen in bed and seemed to be in a good mood. Staff reported increasing pain with repositioning and cares which was improved with medication. - The PCP provided an order for a hospice evaluation for Tenant #5. - The PCP met with Tenant #5 for an acute admission to hospice level of care due to degenerative brain disease. She had a decline in appetite with weight fluctuation. Tenant #5 was experiencing an increase of pain with cares and mobility, spending most of her day in bed.	A 370		

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A 370	Continued From page 8 - Tenant #5 met with her PCP on 8/6/25 for an acute visit due to concerns of her continued bed-bound status. She "is with continued desire to remain in bed". Tenant #5 was with continued resistance with cares and resistance to assistance with getting up. The PCP noted Tenant #5 may be reaching a higher level of care. Staff A was interviewed on 8/19/25 at 3:10 PM and reported Tenant #5 was unable to walk. As far as she knew, Tenant #5 had not left her bed for the past 2-3 weeks. An interview was conducted with Staff B on 8/19/25 at 10:40 AM and she reported Tenant #5 had been bed-bound for about a month. On 8/19/25 at 3:45 PM Staff C reported she did not think Tenant #5 had left her bed in about a month. She received toileting assistance in bed, which usually required two staff. Tenant #5's service plan was not updated to reflect she had not left her bed for an extended period of time and providing staff direction for meeting her needs. 3) Tenant C1 had a service plan dated 5/2/25. The service plan made no reference to Tenant C1 having a skin tear, blood clot or the discontinuation of the majority of medical care to receive what is known as "comfort care" as she neared the end of her life. A review of Nurse's Notes and information from Tenant C1's PCP revealed the following: - A nursing note on 6/4/25 identified Tenant C1 had a skin tear to her left calf. Her PCP ordered	A 370		

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A 370	Continued From page 9 daily dressing changes. - Tenant C1's PCP met with her on 6/4/25 for acute concerns of changes in color and temperature of the left leg. The PCP noted Tenant C1 had darkened purple discoloration, a cool foot and a warm upper left shin. She was in pain when placing pressure on her foot. There was a wound present to her shin, ecchymotic bruising with a skin tear to the proximal/lateral knee. - The dressing change to the left leg was discontinued on 6/16/25. The wound was to remain open to the air. - The program had a care conference with Tenant C1's daughter/power-of-attorney on 6/17/25. A decision was made to begin comfort cares and end non-comfort medication. Tenant C1's service plan was not updated to reflect the changes to her left leg or the changes to her care as she reached the end of her life. During an exit meeting on 8/20/25 at 1:30 PM the Executive Director and Resident Care Director confirmed the program failed to update tenants' service plans as their needs changed.	A 370		