STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165411	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southfield Wellness Community	2416 Des Moines Street Webster City, IA 50595

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, resident, and staff interviews the facility failed to provide the residents with a comfortable homelike environment by failing to keep a resident bed in functioning order and the toilet properly maintained. The facility reported a census of 56 residents. Findings include:Observation on 9/29/25 at 11:20 a.m., revealed, the footboard in Resident #1's room, split in half with silver brackets placed on the inside holding the foot board together.Observation on 9/30/25 at 1:30 p.m., revealed the footboard in Resident #1's room, split in half with silver brackets placed on the inside holding the footboard together.Interview on 9/30/25 at 1:30 p.m., Resident #1 explained the footboard has been broken since they admitted to the facility in July and they are afraid to sleep in the bed causing the footboard to break and falling out of bed. Resident #1 also commented that their bathroom toilet was not working for a couple of days and that they had to use a commode and is embarrassed with the commode still in their room.A work order, given to the surveyor on 10/1/25 at 2:00 p.m., by the Administrator, documented a created dated 8/13/25 at 5:00 p.m., toilet is now broken, work order for new toilet in progress.A receipt dated 8/14/25 at 12:15 p.m., documented toilet purchased due to needing replaced.Interview on 10/1/25 at 9:45 a.m., Staff A, Maintenance, and Staff B, Maintenance, confirmed that Resident #1 toilet was broken for a couple of days a month ago, not sure of the exact date, and that a work order was filled out. Staff B replaced the foot board on the evening of 9/30/25, when they became aware by the surveyor that it was broken, and was not aware on how long the foot board had been broken. Staff A stated that staff pull on the foot board and they break easily. Staff A and Staff B were not aware of any audits or scheduled room checks to be completed for residents' beds, toilets or furnishing.

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical document review, staff interview, the facility failed to ensure that each resident's medication regimen is free from unnecessary medications for 1 of 3 residents (Resident #2) reviewed. The facility reported a census of 56 residents. Findings include:Resident #2's Minimum Data Set (MDS) assessment dated [DATE] documented the resident has short term memory impairments, moderately impaired decision making abilities, substantial to maximal assistance with activities of daily living, and behavioral symptoms not directed towards others (hitting or scratching self, pacing, rummaging, disrobing in public, throwing or smearing food or verbal/vocal symptoms like screaming, disruptive sounds). The MDS included diagnoses of anxiety, bipolar disorder and schizophrenia. The MDS indicated 2 falls with no injury since the prior assessment, and receives antipsychotic, antianxiety and antidepressant medications that were used in the last 7 days of the look back period.The Care Plan Focus target date 8/18/25, indicated Resident #4 has serious mental health diagnoses including bipolar disorder and schizoaffective disorder, these may impact my mood, cognition, and how they interact with staff or other residents. Interventions include to always approach them with positive, kind, and patient mannerisms. They respond best to this approach, help them to understand that taking their medication routinely is very important to maintaining their mental health, and sometimes they may refuse to take it. Encourage adequate rest periods, family visits, and to attend activity of choice.The Behavior Note dated 6/19/25 at 1:15 PM, documented Certified Nursing Assistant (CNA) reported that resident went into another resident room to use the bathroom. Reported that resident has been wandering more, more confused than normal. The Health Status Note dated 6/23/25 at 12:54 PM, identified that resident is having increased confusion, and increased difficulty completing cued tasks. CNA reported when directed to sit down, resident appears confused. CNA reported that it took several times of verbally cueing before resident snapped out of it and sat down. RN observes resident this morning and noted several episodes of the same. RN is talking to resident, and it like the resident freezes, starring off, right past this RN. No blinking, eyes appear fixed straight head. This RN waves hand in front of the resident, calling his name a couple of times and then the resident looks at this nurse briefly, then start rocking. This is different from resident baseline.The Health Status Note dated 6/23/25 at 5:31 PM, documented resident is ambulating back from supper and has a large projectile emesis in the hallway. Resident keeps walking and goes and sits down in the chair at the nurses station.The Behavior Note dated 6/24/25 at 9:29 AM, documented resident wandered into another resident's room and sat on the bed. The nurse attempted to redirect the resident to go to his room. However, the resident was unwilling. This nurse had another staff member assist and was able to convince resident to walk to his room.The Incident Report dated 6/25/25 at 2:42 PM, Describe the Situation as this nurse was called to D hallway right around lunchtime. Resident was found lying in the hallway right after the doorway into D hall. Staff stated that she found him on the floor. There was another resident next to him who was in a wheelchair that had his foot pedals sticking out from his wheelchair. Resident also goes fast when he walks and is reminded numerous times to slow down.The Behavior Note dated 6/27/25 at 3:50 AM, documented Behavior Observed: Throughout the first half of the shift, resident was continuously wandering, more than usual. Resident was also gathering items from his room and carrying them around with him - a picture frame, and random clothing. During the wanderings - resident would randomly stop and 'space out', as if he forgot what to do. Unable to follow directions most ofthe time.The Incident Report dated 6/29/25 at 8:30 PM, Describe Situation: This nurse called to resident's room with staff reporting that he is on the floor. Resident observed by this nurse laying on the floor facing bed with knees bent. Resident does not have shoes on at this time.The Health Status Note dated 6/30/25 at 6:27 PM, documented that resident is having difficulty with walking and standing today. Took 4 staff to get him up out of the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower and into a wheelchair. Resident roamed around in a wheelchair the majority of the day.The Psychiatric Initial Evaluation Service note dated 7/1/25, identified that the chief complaint is psychiatric evaluation and medication management. Evaluation is requested by Administrator related to patient increased in behaviors. Per staff report appears nobody is home at most times Three falls in one-month, increased confusion, off balance, can't find seat easily any longer requiring additional time and safety measures, four staff to get out of shower the other day because he cannot follow simple task/directions. Wandering into other rooms, found in another couple's room and in another patient's bed while they were not in their room. Used to exit seek looking for parents (wears a wander guard on his wrist). All symptoms worsening over the past month. Parents visit most daily. New Orders:Increase noon Haldol to 2 milligrams (mg) by mouth and continue 2 mg Haldol at AM and PM as previously ordered.Increase Bupropion SR to 200 mg twice a day instead of every dayContinue Cogentin as ordered for (rocking)New Order Follow up note dated 7/2/25 at 00:31 AM, indicated that Resident received 1st dose of increased Bupropion SR to 200 mg to twice a day (BID) at hour of sleep (HS). Resident attempted to refuse all HS medications, but the nurse got him to take the Bupropion, Clonazepam and Atorvastatin. Benztropine, Haldol and Metoclopramide weren't given due to adamant refusal with multiple attempts. Resident continues to stare into space and not be willing/able to respond at times when spoken to.The Behavior Note dated 7/7/25 at 4:40 PM, documented resident is sitting on chair in entry way in front of main office. Looking toward door to go outside. Staff offered to go with to dining room to get ice cream, he agreed to go with Nurse. Once stood up went to exit door setting off alarm. Agreed to again go to dining room but had a blank stare and would not move or take steps. Wheelchair offered and he sat in chair. Ok to go to dining room in wheelchair. Laughed at staff and said, It's alright isn't it.The New Order Note dated 7/7/25 at 4:55 PM, Late Entry: Order received and noted for the following: Decrease Clonazepam to 0.5 mg twice daily for falls.The New Order Note dated 7/8/25 at 00:26 AM, to decrease clonazepam from three times a day (TID) to BID.The Incident Report Note dated 7/8/25 at 5:30 PM, indicated the RN is called to the dining room for a fall. When RN enters the dining room, resident is on his knees and hands. Fall was witnessed by several people, and it is reported that resident did not hit his head. Resident is unable to report what had happened but states were getting better aren't we?.The Health Status Note dated 7/8/25 at 9:47 PM, Text: Resident is sitting up at the back nurses' station. Increased confusion noted. Resident is unable to follow commands. Resident is pleasant with staff. Some increased anxiety noted with the increased confusion.The New Order Note dated 7/10/25 at 3:54 AM. Clarification: written order states decrease clonazepam to 0.5 mg BID. Previous order was 0.25 mg TID.The Progress Note dated 7/10/25 with no time documented the chief complaint and presenting problem is acute falls, staff request to be seen. Patient seen and evaluated today for follow up falls and impulsiveness. Last fall on 7/8/25. Staff report several recent falls, including an instance of the patient attempting to throw himself out of his wheelchair. Patient exhibits difficulty in being redirected and does not follow command, increasing fall risk.The Incident Report dated 7/10/25 at 11:46 AM, documented Resident was found scooting on the floor in his room between the bathroom and his bed. Resident had a skin tear on his right knee and also two more skin tears on his left elbow next to another skin tear from his previous fall. Resident was then assisted by overnight nurse and dayshift nurse as well as an aide using a gait belt to get resident off the floor. Resident was sat on his bed as he was very unsteady. The aide went and grabbed a wheelchair to take the resident out to the nurse's station in.The Health Status Note dated 7/12/25 at 5:08 AM, documented, Resident was getting restless after supper, sat in wheelchair up at nurses' station, and noted resident started to try to stand up. Medication aide and male CNA were told to please offer the bathroom, assist resident to help prevent a fall. The nurse stepped away to get a treatment done, was gone five minutes came back to a CNA running to lower the resident when he had self-transferred and lost his balance.The Communication with the Physician dated 7/13/25 at 3:06 PM, indicated telephone call made to clarify the order received on 7/8/25 as follows: - Decrease Clonazepam to 0.5 mg twice daily for falls. Prior to this order, the Resident was (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered: clonazepam Oral Tablet 0.5mg, Give 0.5 tablet by mouth three times daily. Updated provider on medication change, current order, previous order and that this was not a decrease but rather resident is receiving more than before. Updated that this morning this nurse only administered 0.25 mg. The Health Status Note dated 7/13/25 at 8:40 PM, late entry, documented Resident was heard quarreling with other Resident inside their room where he had walked in unnoticed. Was hit on the right side of face and pushed with a table to the right side of his abdomen. No injuries noted at this time. Assisted by two staff hand to hand back to his room. Resisting to be directed and combative. Offered to use bathroom but declined, offered snack but also refused. Assisted to bed and monitored closely.The Health Status Note dated 7/14/25 at 3:20 PM, indicated that resident awake again at midnight and pacing along the hallway. Not able to explain his needs. Checked and brief dry, assisted to bed, repeatedly times 4 in intervals awake and pacing.The Order Note dated 7/14/25 at 3:30 PM, received the following order on doctors' rounds: Clonazepam 0.5 mg by mouth three times a day times 7 days.The Incident Report dated 7/16/25 at 3:30 PM, late entry, Staff reported that resident was sitting in a tall back chair at the nurses' station and then just fell out of the chair. CNA reported that resident fell out towards and onto his right side. CNA witnessed the fall and reported no head contact was made. Resident was wearing shoes, area was clear of clutter, plenty of light, and carpeted.The Behavior Follow up Note dated 7/17/25 at 1:48 PM, Resident has been less anxious throughout today thus far. No attempts made to exit the facility. Resident did however try to enter a resident's room but was stopped at the door and easily redirected. Resident has attended both meals, needing more assistance with eating. At breakfast, resident had to be totally assisted and at lunch did better once he was started. Cognition fluctuates from day to day, hour to hour.The Health Status Note dated 7/19/25 at 5:56 AM, Resident was pacing continuously throughout the first half of the shift. Resident started disrobing completely and coming out into the hall between and had to be assisted with re-dressing several times. When trying to assist resident with dressing, he would try to take them right back off before finishing with dressing. At times, he would get upset and start mumbling and cussing at staff. Resident disrobed at least 7 times within this time. He was extremely difficult to redirect with most of the interactions. When a third staff member attempted to assist with dressing, he laid down and finally stayed dressed. The Incident Report dated 7/21/25 at 1:20 PM, late entry, RN is called to resident's room with report of resident fall. RN enters the room. Resident is noted in the bathroom, on his knees. Pants down, 1 shoe on, sheet and blanket on the bathroom floor. There was plenty of light, no debris, urine and bowel on the floor. CNA reported that she checked on resident 15 minutes prior and he was in his bed with his eyes closed.The No Type Specified Note dated 7/23/25 at 4:22 PM, Family is quite concerned about the medication changes that have been completed this should be discussed with primary care provider. Encouraged family to discuss patient medication changes with primary care provider.The Incident Report dated 7/28/25 at 11:40 PM, documented the nurse called to resident's room 'STAT' (immediately) by staff. Staff was in a room next door and her a 'thud'. Upon entering the room to check on noise, resident noted to be on the floor facing the bathroom on his hands and knees.The Health Status Note dated 7/30/25 at 8:40 AM, late entry, documented, Resident has had a change in cognition over the recent months. Seems to have more difficulty with understanding what is being asked of him. If RN tells him to sit down in the chair, resident will look at the chair but then is confused on how to sit. This makes cueing resident to complete a task much more difficult and can be time consuming. At times resident will get frustrated. CNA was ambulating with resident back from the dining room post breakfast when RN hears CNA say, Ow, Ow, stop squeezing my hand. Resident continues to squeeze CNA hand and had to pry resident's hand off. Then resident is guided/assisted to sit in the chair at the nurses' station. The resident turns and is looking at the seat but missing it when sits. The resident had to be lifted into the chair by 2 staff, then lifted back in the chair by 3 staff. It's not that the resident can't do it, it's that resident is not understanding how to do it in the moment. Cognition fluctuates from day to day, every day is different. The Incident Report dated 8/3/25 at 3:05 AM, documented, the nurse and another staff member looked down the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hall and noticed the resident lying on the floor outside of his room, in the hallway. The nurse and staff went to the resident's aid. Resident was observed lying on the floor with only socks on. Blood noted on floor in several spots near resident.New Order follow up note dated 8/8/25 at 00:19 AM, documented Resident received the decreased doses of Haloperidol, Wellbutrin and benztropine today. Resident came out to hallway to walk around. This nurse asked if he like to sit in a chair for a bit. Resident sat in a chair, near the back nurses' station. Resident was pleasant and cooperative with staff. Resident then went back to his room and has been resting in bed with eyes closed.The Pharmacy Review-Gradual Dose Reduction (GDR) request for Psychotropic Medications dated 1/19/25, recommended to please follow up with the Provider on the next visit for continued need for Haldol oral tablet 2 mg, Give 0.5 tablet by mouth one time a day at lunch and Haldol oral tablet 2 mg, give 1 tablet by mouth two times a day. If a dose reduction is not in his best interest, please note a patient specific clinical rationale below. The form signed by the provider on 4/22/25, Patient is stable on current medications and likely to have harm with GDR attempt after previous failed GDR attempts.Interview on 10/2/25 at 9:00 AM, the facility Director of Nursing, acknowledged that the resident received a lot of psychotropic medications and that the clinical record lacked documentation of a GDR or an attempt to decrease the medications to see if that contributed to the change in condition or falls. The DON verified that it is the goal of the facility is keeping resident off as many medications that they can, that are not necessary. The DON stated that the facility follows the guidelines for Unnecessary Medications per the State Operations Manual.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, resident and staff interviews, the facility failed to provide a professional standard of quality by not following physician orders for 1 of 3 residents reviewed (Resident #3). The facility reported a census of 56 residents.Findings include: Findings include:Resident #3's Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 for which indicated no impaired cognitive memory, is able to be understood and understands others, with no mood or behavior issues. The MDS listed Resident #3 as dependent with toileting hygiene and had an indwelling catheter. The MDS included diagnoses of hypertension (a condition in which the force of the blood against the artery walls is too high), neurogenic bladder (a term used for urinary conditions caused by nerve problems affecting bladder control), diabetes mellitus, and multiple sclerosis.The Care Plan Target dated 11/23/25, indicated Resident #3 is at risk for complications related to resident requiring the use of a suprapubic catheter (a thin, flexible tube inserted into the bladder through a small incision in the lower abdomen to drain urine) related to Neurogenic Bladder. The interventions include change catheter per order. Ensure dignity bag remains in place, monitor tubing for kinks and leaks and ensure tubing remains off the floor, monitor for pain/discomfort due to catheter use, provide catheter care. Monitor for signs and symptoms of urinary tract infection. Report to provider as needed. Urology consults as needed, chronic urinary disturbance, chronic catheter. Observe for signs and symptoms of urinary tract infection, change catheter bag per physician's order.The Medication Review Report signed and dated by the Primary Care Provider on 7/2/25, instructed to change suprapubic catheter every 14 days with a silastic (a type of urinary catheter that features a smooth, non-stick silicone exterior coating a firm, but flexible, latex-based construction) urinary catheter.The Health Status Note dated 7/3/25 at 4:36 PM, indicated that the Certified Nursing Assistant (CNA) reported that resident has not had any output in her catheter drainage bag for the last 2 days and has been very wet/incontinent of urine. Resident is assisted to bed to lie down per nurse direction. Nurse to room to check if catheter needed to be repositioned or changed due to occlusion (the blocking or closing of an opening). Balloon is deflated and deep dark red blood is noted in the tubing. Then had resident take a deep breath to remove catheter, attempted to remove but met with resistance so ceased. Suprapubic site is cleansed, and catheter is gently turned then removed. New silastic catheter was placed without complaints of discomfort with only scant (small amount) returned. CNA assisted resident to the bathroom, while resident is in the bathroom, CNA calls this nurse to resident room with reports of catheter coming out the vagina. Reports resident is still leaking urine out of the vagina with scant amount of urine in the drainage bag. Upon assessment it is noted that resident's catheter is sticking out of the perineal area. Call placed to resident's urology clinic to report and ask for guidance. Clinic reports to monitor for urine output. If resident spikes a temperature, has a moderate amount of bleeding, or significant amount of pain - it is suggested resident be evaluated in the emergency room (ER).The Health Status Note on 7/4/25 at 12:25 PM, indicated: The nurse was called into resident's room this morning. Resident had very little output and her brief was drenched. Asked resident if she wanted to go the ER or what she wanted to do. Resident got into the shower and got cleaned up. The nurse contacted son and the hospital (ER). Resident was transported at 11:00 AM.The Health Status Noted on 7/4/25 at 4:57 PM, indicated that the resident returned to facility. Diagnosis was obstruction of suprapubic catheter, initial encounter. New catheter was placed.The Health Status Note on 7/5/25 at 1:58 AM, indicated that resident's new catheter remained patent and draining with straw colored urine. No abdominal distention noted, resident denied pain. Continue to monitor.The Communication Report with the Resident on 7/20/25 at 11:11 PM, indicated the Suprapubic catheter changed per schedule. Catheter changed using silicone catheter, using sterile technique. Immediate return of straw-colored urine. Some discomfort with insertion. Catheter is patent and draining.The (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Status Note dated 7/24/25 at 10:06 AM, indicated that a phone call was placed to clinic. Resident has dried blood around catheter site and is complaining of same pain. Resident had only a small amount of urine in her catheter bag but stated that she was soaked this morning. Waiting for a return call.The New Order Note dated 7/25/25 at 4:10 PM, indicated that the resident returned from appointment without incident. Catheter was changed at appointment with the doctor (Dr.) using a Silastic catheter. Resident returned with the following directions. Plan: Suprapubic tube exchanged today-Continue every two-week exchange using silastic catheter NOT silicone.The Health Status Note dated 7/29/25 at 10:53 AM, indicated a phone call placed to physician about resident having blood around catheter site and having discomfort around insertion site. Spoke with receptionist and gave an update, then spoke to the nurse. She was going to talk with Dr. and call back. She stated that the blood is more than likely from the irritation from the previous catheter.The Health Status Note dated 7/29/25 at 2:56 PM, indicated that the Dr.'s nurse returned call, Dr. stated that no change from appointment on Friday. Stated that to continue to monitor resident, but it would take time for her to heal due to the previous catheter that was being used.The Progress Notes from the Office visit dated 7/25/25, indicated the resident returned in follow up for a chief complaint of a suprapubic catheter obstruction. Resident has a history of neurogenic bladder secondary to Multiple Sclerosis and now living with a chronic suprapubic catheter which is exchanged monthly by her home nurse. She was seen in the emergency room on 7/4/25 with catheter obstruction and leaking around the suprapubic site. Apparently, the suprapubic catheter had exited the urethra and was in the vagina, but it was exchanged in the ER and obstructed urine was drained. She continued to have some bleeding around the suprapubic site. They are using a silicone catheter. Plan is to continue every 2-week exchange using catheter (latex or silastic is fine but NOT silicone).Interview on 9/30/25 at 1:00 PM, Resident #3, stated that the nurse attempted to put the silicone catheter into the suprapubic site at least 4 times. The end of the catheter that was being used had a square end on it and would get caught. Resident #3 expressed concerns that the nurse was using the wrong type of catheter and that caused the stoma to get irritated and sore, and orders were received for an ointment to be used. The resident reported that she knows her body very well and that a silastic catheter tubing works the best.Interview on 9/30/25 at 2:00 PM, Staff C, Registered Nurse (RN), stated that a silastic catheter is the type of catheter that the physician ordered for Resident #3. Staff C explained that on 7/3/25, a CNA came and explained that something was wrong with the catheter with Resident #3. Staff C indicated that when she went to investigate, she noticed that a catheter was in the vagina of the resident. Staff C indicated that the catheter was not a silastic catheter tubing and confirmed that it was a silicone catheter. Interview on 10/2/25 at 11:00 AM, the facility's Director of Nursing (DON) confirmed that the staff are expected to follow the physician's orders as directed by using a silastic catheter and not a silicone. The DON explained that the facility followed the standards of practice for following physician orders.

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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** Based on observation, clinical record review, staff and resident interview, the facility failed to assess a resident that had no urinary output in their catheter bag for two days for which resulted in the resident going to the Emergency Department with discomfort (Resident #3) for 1 of 3 resident reviewed. The facility identified a census of 56 residents.Findings include:Resident #3 Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 for which indicated no impaired cognitive decisions, is able to be understood and understands and no behavior or mood issues. The resident required dependent assistance for activity of daily livings (ADL) and an indwelling catheter used for urinary output. The MDS included diagnoses of neurogenic bladder, (an injury or disease that interrupts the electrical signals between your nervous system and bladder function) diabetes mellitus, pneumonia, multiple sclerosis, depression and sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection).The Care Plan Focus with a target dated 11/23/25, indicated Resident #3 received an antibiotic therapy related to chronic catheter and urinary tract infections (UTI), and is at risk for complications related to chronic urinary disturbance. Interventions include to encourage to drink fluids, medications as ordered and observe for signs and symptoms of UTI, monitor for pain/discomfort due to catheter use.The Documentation Survey Report dated July 2025, indicated no urinary output on the following shift and dates.a. Night shift: 7/1/25, 7/3/25 and 7/4/25b. Day shift: 7/2/25, and 7/3/25.The Health Status Note dated 7/3/25 at 4:36 PM, identified that the Certified Nursing Assistants (CNA) report that resident has not had any output in her catheter drainage bag for the last 2 days and has been very wet/incontinent of urine. Registered Nurse (RN) to check if catheter needed to be repositioned or changed due to occlusion. Balloon is deflated and deep dark red blood is noted in the tubing. New catheter placed with only small amount of urine obtained. Clinic reports to monitor for urine output. If resident spikes a temperature, has a moderate amount of bleeding, or significant amount of pain, it is suggested resident be evaluated in the Emergency Room.The Health Status Note dated 7/4/25 at 12:25 PM, documented the nurse was called into residents' room this morning. Resident had very little output and her brief was drenched. Asked resident if she wanted to go to the ER. Resident was transported via facility van.The Health Status Note dated 7/4/25 at 4:57 PM, documented resident returned with diagnosis of obstruction of suprapubic catheter and had a new catheter placed. The After Visit Summary Note dated 7/4/25, documented reason for visit as urinary retention, diagnosis of obstruction of suprapubic catheter.Interview on 9/30/25 at 1:00 PM, Resident #3 acknowledged and verified that she had no urinary output for 2 days and had pain/discomfort and requested to go to the Emergency Room.Interview on 9/30/25 at 2:00 PM, Staff C, Registered Nurse (RN), verified Resident #3 had no urinary output for 2 days and it is the expectation of the staff to notify if no urinary output after one shift.Interview on 10/2/25 at 11:00 AM, the facility Director of Nursing acknowledged Resident #3 had no urinary output for 2 days and that it is the expectation of the floor staff to notify the charge nurse if no urinary output at the end of their shift. The Director of Nursing stated that the facility follows the standards of practice for documenting urinary output.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165411	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southfield Wellness Community	2416 Des Moines Street Webster City, IA 50595

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical document review, resident and staff interview, the facility failed to provide adequate nursing supervision for 1 of 3 residents (Resident #4) reviewed. The facility reported a census of 56 residents. Findings include:Resident #4's Minimum Data Set (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 14 for which indicated no impaired cognitive decisions, is able to be understood and understands and no behaviors. The resident required partial to moderate assistance with activity of daily living and had 2 falls with no injury prior to being admitted to the facility. The MDS included diagnoses of heart failure, hypertension, diabetes mellitus, Parkinsons, anxiety, and depression.The Care Plan Focus target dated 12/4/25, indicated Resident #4 is at risk for falls related to gait imbalance. Interventions include to assist resident with ambulation and transfers as needed, bed is in low position, resident to leave bedroom door open for closer supervision and signage on walker to remind resident to use assistive device and call for assistance.The Incident Report dated 8/12/25 at 8:35 AM, described the situation as nurse called to resident's room. Observed resident sitting on the floor in front of the bathroom door with scooter on his left side. Certified Nursing Assistant (CNA) was walking by resident room and witnessed him lowering himself to the floor and resident did not hit his head. Resident wearing appropriate footwear, call light pendent around neck, resident checked on hourly and door open for closer observation.The Incident Report dated 8/2/25 at 3:15 PM, described the situation as nurse was called to resident room that resident was on the floor. Resident said he took himself to the bathroom and was washing his hands when knee gave out. Further preventative measures include to check on resident hourly to see if he needs assistance.The Incident Report dated 8/15/25 at 9:15 PM, described that CNA went to answer call light when opened the door noted resident on the floor in front of recliner. Left side against recliner and right hand on the walker. Further preventative measures include to door to room to be left open when alone in room.The Incident Report dated 8/15/25 at 10:00 PM, described the situation as CNA opened the door of room and witnessed start of fall but could not get to resident in time. Reports resident did not hit head. Interview on 9/30/25 at 3:00 PM, Resident #4 was not able to recall if staff check on him every hour but stated that his room door is closed frequently.Interview on 10/1/25 at 2:45 PM, the facility Director of Nursing acknowledged that the clinical record lacked documentation of hourly checks being completed and the expectation is the staff are to complete since it was an intervention. The facility does not have a policy on falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165411	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southfield Wellness Community	2416 Des Moines Street Webster City, IA 50595

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on electronic health records (EHR), document review, resident interview, and staff interview the facility failed to provide nursing staff to assure residents safety by not responding to call lights in a timely manner for 4 of 4 residents reviewed (Residents #1, #3, #4, and #6). The facility reported a census of 56 residents.Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #1 documented a Brief Interview for Mental Status (BIMS) of 6 indicating cognitive impairment. Review of Electronic Health Record (EHR) documented Resident #1 resided in room D17.Interview on 9/30/25 at 1:30 PM Resident #1 stated the facility was short of staff on the evening shift. Resident #9 stated she had to wait longer than 15 minutes to have her call light answered. Review of document titled, Past Call Report for room number D17 documented on 9/28/25 call light was turned on at 10:37 AM and to room elapsed time of 18 minutes.2. The MDS dated [DATE] for Resident #3 documented a BIMS score of 15 for which indicated no cognitive impairment.Review of the EHR documented Resident #3 resided in room D23.Interview on 9/30/25 at 1:00 PM, Resident #3 stated that she had to wait longer than 15 minutes to have her call light answered.Review of the document titled, Past Call Report for room number D23 documented on 9/28/25 call light was turned on at 10:02 PM and to room elapsed time of 20 minutes.3. The MDS dated [DATE] for Resident #4 documented a BIMS score of 14 for which indicated no cognitive impairment.Review of the EHR documented Resident #4 resided in room C14Review of the document titled, Past Call Report for room number C14, documented on 9/26/25, call light was turned on at 8:31 AM and to room elapsed time of 22 minutes, on 9/27/25, call light was turned on at 6:21 AM and to room elapsed time of 22 minutes and on 9/29/25, call light was turned on at 6:29 PM with to room elapsed time of 24 minutes.4. The MDS dated [DATE] for Resident #6 documented a BIMS score of 15 for which indicated no cognitive impairment.Review of the EHR documented Resident #6 resided in room B42Interview on 9/30/25 at 8:30 AM, Resident #6 stated that it takes longer than 15 minutes to have her call light answered.Review of the document titled, Past Call Report for room number B42 documented on 9/27/25, call light was turned on 5:14 AM and to room elapsed time of 16 minutes. On 9/29/25, call light was turned on at 12:50 PM and to room elapsed time of 21 minutes. Interview on 9/30/25 at 2:15 PM, Staff D, Licensed Practical Nurse (LPN), acknowledged that the call lights take longer than 15 minutes to answer on the evening shift due to short of staff.Interview on 10/1/25 at 2:00 PM, the facility Administrator and Director of Nursing acknowledged that the call lights are over the 15 minutes and that the expecation are for staff to answer within the 15 minutes per the guidelines.Interview on 10/1/25 at 4:45 PM, Staff E, Certified Nursing Assistant (CNA), verified that it takes longer than 15 minutes to answer call lights due to short staff on the evening shift.The Call Light Policy dated September 2023, instructed to ensure a prompt response to the residents call for assistance. The facility also ensures that the call system is in proper working order. Facility shall answer call lights in a timely manner.