

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Southfield Wellness Community		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Immediate jeopardy to resident health or safety 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 record review, staff interviews, camera/video footage review and policy review, the facility failed to provide adequate supervision and operational alarm safeguards to prevent the elopement for 1 of 1 resident reviewed (Resident #7). On 7/17/26 at 3:45 PM, Resident #7 exited the building unattended. At 3:46 PM, Staff F, Dietary Staff member entered the lobby and shut off both the door alarm and wander guard alarm (across 2 separate keypads) without investigating the cause or checking the exit. Another resident (Resident #12) asked Staff G, Certified Medication Aide (CMA) if she was going to get Resident #7 who went outside. At 3:50 PM, Staff G, CMA asked staff via walkie-talkie if anyone saw Resident #7. Staff G, CMA retrieved Resident #7 from the parking lot of the facility at 3:52 PM. The facility sits at the end of a residential road, 0.1 miles (approx. 500 feet) north of Highway 20-a high-speed road with a 65-mph speed limit-separated only by grass and trees. An unmonitored resident wandering onto a 65-mph highway creates an immediate risk of severe vehicular trauma or death. Additionally, the Climatologist measured the temperature at 90 degrees with a heat index of 103 degrees. Resident #7 wore a long-sleeve t-shirt, sweatpants, and shoes, creating a rapid risk of severe heat exhaustion, hyperthermia, heat stroke, or death. The State Agency informed the facility of the Immediate Jeopardy (IJ) on 7/23/26 at 11:08 AM that began as of 7/17/26. The Facility Staff removed the IJ on 7/17/26 through the following actions: -Resident #7 was assessed immediately on 7/17/26 with no negative findings. -Resident head count completed and everyone accounted for. -House wide facility staff education initiated on 7/17/26 regarding door alarm and wander guard alarm response. -Staff who are currently on leave or new agency staff will receive training prior to the next scheduled shift. -Newly hired staff will be trained regarding door alarm protocols and Wanderguard alarm response during orientation. -Door alarm audit and Wanderguard audits were completed on 7/17/26 and continued daily with no negative findings. - Staff F, Dietary Aide, received verbal warning on 7/17/26. The scope lowered from a J to D at the time of the survey after ensuring the facility implemented education regarding the door and Wanderguard alarms. The facility reported a census of 56 residents. Findings include: Resident #7's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 4, indicating severely cognitively impaired. Resident #7's MDS documented Resident #7 required partial or moderate assistance with transfers and ambulation (walking). Diagnoses included cerebrovascular accident (stroke), coronary artery disease (clogged heart arteries), diabetes mellitus (high blood sugar), and legal blindness (severe vision loss). Resident #7's MDS documented Resident #7 didn't use a wander or elopement alarm. Resident #7's Care Plan with a target date of 10/4/26 documented Resident #7 at risk for elopement or wandering related to confusion and impaired cognition. The Care Plan documented the following interventions with implementation dates: Alert (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
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Southfield Wellness Community		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Immediate jeopardy to resident health or safety Residents Affected - Few	bracelet or Wanderguard - 7/17/26Staff to check alert bracelet and placement every shift and function every day - 7/17/26Staff to engage Resident #7 in purposeful activities - 5/8/26Provide care in a calm and reassuring manner - 5/8/26Provide care in simple instructions - 5/8/26Provide reorientation to surroundings and environment - 5/8/26 A Progress Note dated 6/19/26 at 10:17 PM documented Resident #7 wandering into another resident's room and sitting in a closet in a room across the hall. A Progress Note dated 6/28/26 at 7:02 AM documented Resident #7 staying up all night wandering with a walker. The note documented staff observing from a distance due to agitation, and documented Resident #7 experiencing confusion, reporting military service and staff holding Resident #7 back from saving people. A Progress Note dated 6/28/26 at 7:54 AM documented Resident #7 requiring one-on-one (1:1) supervision most of the morning due to exit seeking. A Progress Note dated 7/1/26 at 7:05 PM documented Resident #7 wandering throughout the facility, needing constant prompts to use the walker. Resident #7 displayed dangerous transfer habits, including sitting on a walker with one knee, placing hands on the wall, attempting to scoot down the wall to sit on the floor, and walking backwards. A Progress Note dated 7/4/26 at 9:42 AM documented Resident #7 wandering since the nurse arrived in the morning, requiring staff intervention when Resident #7 left the walker to continue walking. The note documented Resident #7 required one-on-one (1:1) supervision most of the morning. A review of the Clinical Record showed a lack of an Elopement Risk Evaluation prior to 7/17/26. A review of June and July 2026 Medication Administration Records (MAR) showed a lack of documentation regarding Resident #7's Wanderguard placement and function until 7/18/26. An Incident Report (IR) dated 7/17/26 at 3:45 PM completed by the Director of Nursing (DON), documented at 3:45 PM the Wanderguard and front door alarm sounded. The report documented a staff member shut off the alarm and returned to previous duties. Resident #12 alerted a staff member after observing a resident walk out the door, causing alarms to sound, and the staff member immediately exited the building to locate Resident #7 and redirect Resident #7 inside. A review of facility Camera and Video Footage dated 7/17/26 documented the following:Resident #7 exited the building at 3:45 PM wearing a long-sleeve shirt, sweatpants, and shoes.Staff F, Dietary Aide (DA), manually shut off the door and Wanderguard alarm at 3:46 PM.Staff G, Certified Medication Aide (CMA), approached by Resident #12, headed outside at 3:51 PM.Staff G brought Resident #7 back into the building at 3:52 PM. The Climatologist Report dated 7/22/26 at 1:54 PM documented on 7/17/26 at 3:45 PM in Webster City the outdoor temperature measured 90 degrees Fahrenheit with a heat index of 103 degrees Fahrenheit. Google Maps reviewed 7/23/26 identified the facility sat at the end of a residential road, 0.1 miles (approx. 500 feet) north of Highway 20-a high-speed road with a 65-mph speed limit-separated only by grass and trees. The Employee Warning Notice form dated 7/17/26 documented Staff F responded to an alarm located at the front doorway on 7/17/26. Camera review confirmed staff didn't follow guidelines appropriately when responding to an alarm. The notice documented Wanderguard alarms represent critical safety alerts designed to protect residents at risk for wandering or elopement. Facility policy required all staff to immediately respond and investigate any Wanderguard alarm, regardless of current duties, to ensure resident safety and security. The notice documented failure to respond places residents at risk for adverse outcomes and injury. Staff F wrote on the bottom of the notice not receiving information regarding Wanderguards and checking the perimeter. The DON, the Administrator, and Staff F signed the form on 7/17/26. On 7/22/26 at 6:42 AM the DON stated identifying on 7/17/26 Resident #7's Wanderguard didn't appear on the Care Plan or MAR, and corrected the omissions. The DON acknowledged staff didn't complete an elopement assessment prior to the incident, completing the assessment on 7/17/26. The DON stated expecting the Wanderguard to appear on the Care Plan and MAR, and expecting staff to (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Southfield Wellness Community		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Immediate jeopardy to resident health or safety Residents Affected - Few	complete an elopement assessment upon admission and as needed if identifying a resident as an elopement risk. The DON stated uncertainty regarding when staff implemented Resident #7's Wanderguard. On 7/22/26 at 12:57 PM Staff E, Registered Nurse (RN), stated the front door alarm sounded on 7/17/26 while Staff E performed a treatment on [NAME] Hall. Staff E stated a medication aide reported over the walkie-talkie Resident #7 exited into the parking lot. Staff E stated asking over the walkie-talkie if someone could assist Resident #7 because Staff E remained mid-treatment, and the medication aide reported assisting Resident #7 back inside. Staff E reported the DON informed Staff E a dietary staff member shut off the door alarm without confirming if a resident exited. Staff E stated not observing Resident #7 return to the building because Resident #7 returned before Staff E completed the treatment. Staff E reported Resident #7 wore a Wanderguard at the time of the elopement and stated hearing staff say the door alarm sounded, assuming both alarms sounded. Staff E stated Resident #7 attempted to leave the building once or twice previously, but staff intervened. Staff E stated believing Resident #7 stayed outside around 5 minutes. On 7/22/26 at 1:16 PM Staff F, Certified Medication Aide (CMA), stated walking up front around 3:45 PM to prepare the medication pass. Staff F reported she heard the Wanderguard sound before someone shut it off. Staff F stated Resident #12 asked if Staff F planned to get Resident #7 because they walked outside, and Resident #7's roommate confirmed Resident #7 walked outside. Staff F stated Resident #12 reported someone turned off the alarm and walked away. Staff F stated they walked to the front door, asked over the walkie-talkie if anyone held eyes on Resident #7, and then observed Resident #7 standing in the handicapped parking stall looking around with a walker. Staff F stated Resident #7 reported feeling better outside due to warm weather. Staff F stated bringing Resident #7 back into the building without problems, noting the DON and the Administrator knew about the incident and planned to review the camera to identify who turned off the alarm. On 7/22/26 at 1:59 PM Staff F confirmed they turned off both the Wanderguard alarm and door alarm without checking outside to see if a resident exited the building. Staff F explained they started working at the facility 4 months prior without receiving training regarding alarm responses, adding staff didn't provide door codes. They had to figure out the door codes during the first month after a medication aide provided the code. Staff F stated they heard the front door alarm sound while in the kitchen. They exited through the side kitchen door, hearing the Wanderguard sound, and shut off both alarms at the front door. Staff F stated they looked through the window without seeing anyone, and acknowledged they didn't physically walk outside to check if anyone exited. On 7/23/26 at 8:20 AM the DON stated they planned to add the door alarm checking procedure to all platforms and orientation packets for new staff. The DON stated they expected the charge nurses or Human Resources to review orientation packets with new staff, noting they didn't add the form to orientation packets yet, but started communicating the instructions verbally on 7/17/26. On 7/23/26 at 4:12 PM Staff B, Certified Nursing Assistant (CNA), stated they worked from 6:00 AM to 2:00 PM on 7/20/26. Staff B asked about door alarms and codes upon arriving at a new facility because the facility didn't provide the information automatically. Staff B reported they turned off the Wanderguard alarm by the kitchen door on 7/20/26 because the alarm sounded without anyone coming to shut it off. Staff B stated they didn't know who set off the alarm and looked around without knowing whom to look for due to unfamiliarity with residents. Staff B explained they didn't see anyone, acknowledged shutting off the alarm didn't represent the smartest action, and confirmed they didn't check the hallway or outside for a resident. On 7/23/26 at 4:46 PM The Administrator stated an elopement binder remained at the front of the building by the nurse's desk, noting four residents wore Wanderguards. The Administrator reported they updated the binder on 7/17/26 and adding they planned to post a communication note in the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Southfield Wellness Community		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Immediate jeopardy to resident health or safety Residents Affected - Few	electronic medical record [EMR] to ensure staff knew about the binder location. The undated Missing Patient Actions Table protocol instructed staff to react and respond to alarms or possible missing resident concerns immediately, directing the Administrator or Licensed Nurse in charge to assume the role of search coordinator. The facility education policy dated 7/17/26 directed all available staff to respond immediately if a door alarm or Wanderguard sounded. The policy instructed staff to shut off the alarm if staff easily determined the cause and resident, but directed staff to silence the alarm and search immediately the inside and outside areas if the cause remained unknown. The policy directed staff to notify all staff via walkie-talkie to complete a head count and initiate the missing person drill if staff still couldn't determine the cause.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Southfield Wellness Community		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure staff monitored weight loss, followed Dietitian recommendations, and notified the Physician of significant weight loss for 1 of 6 residents reviewed (Resident #1) for weight loss. The facility reported a census of 56 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 3, indicating severely cognitively impaired. Resident #1's MDS documented Resident #1 required setup or cleanup assistance with eating. Resident #1's MDS included diagnoses including cerebrovascular accident (stroke) with left-side hemiplegia (one-sided paralysis), traumatic brain injury (brain damage from trauma), chronic obstructive pulmonary disease (COPD) (long-term lung damage), and coronary artery disease (clogged heart arteries). Resident #1's MDS documented weight loss, they ate a mechanically altered diet (modified food texture), and received hospice services (end-of-life care). Resident #1's Care Plan with a target date of 7/14/26 identified potential nutritional risk related to missing teeth, a mechanically altered diet, fair food intake, and malnutrition (poor nutrition). The Care Plan directed staff to provide diet as ordered, monitor weights, and offer snacks or meal substitutions as appropriate. A Weight/Nutrition Note dated 6/13/26 documented Resident #1 experienced a 13-pound weight loss over 36 days, dropping from 153.4 pounds to 140 pounds. The Registered Dietitian (RD) requested a reweight, recommended trying 8 ounces of Breeze (nutritional supplement) daily, and instructed staff to document refusals. The Weight Summary documented Resident #1 weighed 153.4 pounds on 5/5/26 and 140.4 pounds on 6/10/26, reflecting an 8.46 percent weight loss in 1 month. A review of Resident #1's Clinical Record showed staff didn't obtain a reweight or start the Breeze supplement per RD recommendations. Additionally, Resident #1's Clinical Record showed staff didn't notify Resident #1's Physician regarding the weight loss. On 7/23/26 at 1:23 PM the RD reported Resident #1 held a history of refusing supplements, noting staff needed to document any refusals. The RD recalled speaking with the Director of Nursing (DON) about trying the supplement with Resident #1, instructing staff to document refusals if Resident #1 declined. On 7/23/26 at 1:33 PM the RD reported finding no documentation in Resident #1's Clinical Record showing staff sent weight loss and dietary recommendations to the Physician or hospice. The RD stated reassessing Resident #1 on 6/19/26, noting progress notes indicated Resident #1 actively died and refused food and drink. The RD stated she didn't re-recommend the supplement on 6/19/26 and confirmed finding no record showing staff obtained a reweight or tried the supplement. On 7/23/26 at 2:22 PM the DON verified staff didn't follow up on the reweight or start the Breeze nutritional supplement per dietary recommendations. Additionally, the DON reported she couldn't locate Physician notification regarding the weight loss, stating an expectation for staff to follow up on dietary recommendations and notify the Physician of weight loss. The Weight Management Guidelines policy dated June 2023 directed the RD to review weight changes and make recommendations as necessary. The policy noted staff may implement weight management strategies, including nutritional supplements as ordered, at any time during a resident's stay.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Southfield Wellness Community		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations, resident interviews, facility records review, staff interviews and policy review, the facility failed to provide sufficient staff to meet the needs of residents who resided in the facility (Residents #8, #10 and #11). The facility reported a census of 56 residents. Findings include: 1. Resident #8's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. A review of the Census showed Resident #8 resided in room B42-2. A review of Resident #8's call light reports for room B42-2 from 7/16/26 to 7/23/26 showed the call light remained active for 15 minutes or more on the following dates and times: 7/18/26 at 9:00 PM - 22 minutes 7/19/26 at 5:53 PM - 18 minutes 7/22/26 at 1:12 PM - 19 minutes 7/22/26 at 8:54 PM - 21 minutes On 7/21/26 at 10:53 AM Resident #8 stated staffing didn't feel good. Resident #8 stated call lights can remain active for an hour or more. Resident #8 stated they monitored the call lights using 2 clocks in their room. Resident #8 stated staff explain they are busy with other residents. Resident #8 stated when staff enter the room they should focus on them, but staff receive calls to help other residents. Resident #8 stated they lived at the facility for 9 years and understood how things worked. 2. Resident #10's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. A review of the Census showed Resident #10 resided in private room D24. On 7/22/26 at 7:46 AM an observation showed Resident #10 lying in bed with the call light activated. Resident #10 yelled out asking for help. On 7/22/26 at 8:00 AM an observation showed Resident #10 remaining in bed with the call light activated. Resident #10 yelled out asking for help. On 7/22/26 at 8:21 AM staff answered Resident #10's call light. Resident #10 informed staff of needing to urinate. A review of Resident #10's call light reports for room D24 from 7/16/26 to 7/23/26 showed the call light remained active for 15 minutes or more on the following dates and times: 7/19/26 at 3:00 AM - 45 minutes 7/19/26 at 6:08 AM - 44 minutes 7/21/26 at 8:31 PM - 19 minutes 7/22/26 at 7:46 AM - 36 minutes On 7/22/26 at 8:34 AM Resident #10 stated they felt tired and just got up to use the bathroom. Resident #10 stated the call light can remain active for half an hour at times, requiring them to wait for assistance. 3. Resident #11's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. A review of the Census showed Resident #11 resided in room E29-1. On 7/22/26 at 7:57 AM an observation showed Resident #11's call light activated, and staff answered the call light at 8:15 AM. A review of Resident #11's call light reports for room E29-1 from 7/16/26 to 7/23/26 showed the call light remained active for 15 minutes or more on the following dates and times: 7/16/26 at 8:42 AM - 28 minutes 7/16/26 at 10:54 AM - 20 minutes 7/17/26 at 1:26 AM - 25 minutes 7/17/26 at 9:00 PM - 28 minutes 7/18/26 at 12:19 AM - 18 minutes 7/18/26 at 6:25 AM - 31 minutes 7/18/26 at 8:06 PM - 20 minutes 7/19/26 at 6:45 AM - 52 minutes 7/22/26 at 7:57 AM - 18 minutes On 7/22/26 at 8:45 AM Resident #11 stated staff don't always answer the call light within 15 minutes. Resident #11 stated staff eventually answer call lights, but response times take much longer than 15 minutes. Resident #11 stated the facility doesn't have enough staff to meet resident needs. Resident #11 stated they feared getting in trouble for talking, noting the staff scold them and treat them like a child. On 7/21/26 at 7:37 AM Staff D, Certified Medication Aide (CMA), stated the facility needed a better call light system. Staff D stated 2 monitors exist, one at the front nurse's station and one at the back nurse's station. Staff D stated medication aides and nurses must watch monitors and inform staff (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Southfield Wellness Community		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about active call lights using walkie-talkies. Staff D stated when call lights exceed 15 minutes, Staff D attempts to answer lights, but medication passes sometimes interfere. On 7/21/26 at 9:20 AM Staff A, Certified Nursing Assistant (CNA), stated the facility needs a better call light system. Staff A stated staff must check for call lights at the nurse's station because hallways lack lights and staff don't carry pagers. Staff A stated call lights remain active for half an hour or more at times. Staff A stated seeing monitor displays showing call lights in other hallways active for 45 minutes. Staff A stated attempting to assist other hallways when caught up with duties. Staff A stated reporting concerns to Staff B, Director of Nursing (DON), approximately two weeks prior, and Staff B stated the facility planned to install iPads or kiosks in each hallway to monitor call lights. On 7/22/26 at 7:00 AM Staff C, CMA, questioned why management instructed staff to answer call lights due to state presence, asking if responses shouldn't happen even without state presence. Staff C stated management doesn't leave offices to assist with call lights, creating frustration. Staff C stated the facility experiences long call light response times, not due to lack of staff effort, but because the facility stays very busy. Staff C stated staff lack awareness of active call lights unless walking to the nurse's station to check monitors, delaying response times. Staff C stated some residents, including Resident #10, must yell for help because staff don't know call lights or pendants remain active. Staff C stated the facility lacks sufficient walkie-talkies for all staff. Staff C stated the facility planned to install hallway call light devices, but installation hasn't occurred. Staff C verified the facility utilizes many agency staff and questioned whether walkie-talkies leave with agency staff. Staff C stated feeling bad for residents paying to live at the facility, noting residents don't receive baths or must eat in bed due to inadequate staffing. Staff C expressed hope of not getting in trouble for sharing information, noting issues can't be fixed without speaking up. On 7/22/26 at 12:57 PM Staff E, Registered Nurse (RN), stated call lights sometimes exceed 15 minutes, noting residents using call lights more frequently tend to experience longer wait times. Staff E stated staff don't carry pagers and walking to the nurse's desk to check monitors wastes time, contributing to long call light response times. Staff E stated not hearing resident complaints regarding long call lights, but wouldn't feel surprised if complaints exist. On 7/23/26 at 8:00 AM Staff B stated expecting call lights answered as soon as possible, within 15 minutes. Staff B stated the facility works on installing iPads in hallways and obtaining pagers for staff. Staff F, Administrator, stated hallway brackets for iPads were installed while awaiting required cords, expecting iPad and pager implementation within the next week. The Call Light Policy undated directed staff to ensure prompt responses to resident requests for assistance and maintain call systems in proper working order. The policy directed staff to answer call lights in a timely manner, ensuring triggered call lights alert staff visually, audibly, or both.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Southfield Wellness Community		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on diet orders, staff interviews, clinical record review, and facility policy review the facility failed to serve the appropriate therapeutic diet to meet resident's needs according to their diet order for 1 of 6 residents reviewed (Resident #5). The facility reported a census of 56 residents. Findings include: Resident #5's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 1, indicating severely cognitively impaired. Resident #5's MDS documented Resident #5 required partial or moderate assistance with eating. Resident #5's MDS documented diagnoses including Alzheimer's disease (progressive memory loss disorder), non-Alzheimer's disease (brain disorder causing memory loss), and malnutrition (poor nutrition). Resident #5's MDS documented receipt of a mechanically altered diet (modified food texture). Resident #5's Care Plan with a target date of 7/26/26 documented an actual risk for altered nutritional status related to fair to poor meal intakes and diagnoses of dementia (memory loss). The Care Plan directed staff to provide diet as ordered and assess for signs and symptoms of aspiration (food or liquid entering the lungs) or difficulty swallowing. A diet order dated 4/13/26 directed staff to provide a regular diet with a pureed (smoothly blended) texture and nectar (mildly thick) fluid consistency. A Progress Note dated 7/2/26 documented Staff A, Advanced Registered Nurse Practitioner (ARNP), examined Resident #5 during rounds. Staff A provided new physician orders and feeding instructions directing staff to give honey (moderately thick) thickened liquids, sit on the right side of Resident #5, give a drink after each bite, and continue the pureed diet. A review of Resident #5's clinical record showed staff didn't update the new physician orders and feeding instructions dated 7/2/26 in the Physician's order tab or on the Kardex (care summary sheet). Resident #5's July 2026 Medication Administration Record (MAR) directed staff to administer a 4-ounce mighty shake (nutritional supplement) three times daily for weight loss. The MAR listed the mighty shake as a nectar (mildly thick) thickened liquid. The MAR documented Resident #5 received the nectar thickened mighty shake from 7/2/26 through 7/20/26. On 7/21/26 at 7:07 AM an observation showed a cup of thickened water with a lid and straw sitting on the tray table in Resident #5's room. The lid documented the date 7/21/26. On 7/21/26 at 8:13 AM an observation showed Resident #5 receiving one-on-one feeding assistance from Staff B, Certified Nursing Assistant (CNA), in the dining room. Staff B sat on Resident #5's left side instead of the right side per physician orders. On 7/21/26 at 8:40 AM the Director of Nursing (DON) verified the thickened water in Resident #5's room contained a nectar consistency. On 7/21/26 at 8:46 AM an observation showed Staff C, Certified Medication Aide (CMA), assisting Resident #5 with a mighty shake. Staff C sat on Resident #5's left side. On 7/21/26 at 10:45 AM the Director of Nursing (DON) acknowledged staff didn't transcribe the physician orders dated 7/2/26 to Resident #5's electronic medical record. The Physician Order/Transcription of Orders policy dated July 2023 instructed staff to correctly and safely receive and transcribe physician orders so staff follow and administer correct orders. The policy directed staff to enter orders into a resident's medical record exactly as stated or written by the Provider, and directed staff to follow and carry out active orders as written or transcribed.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Southfield Wellness Community		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, record review, and interview, the facility failed to ensure staff accurately documented meal intakes in the Electronic Medical Record (EMR) for 1 of 11 residents reviewed (Resident #6). The facility reported a census of 56 residents. Findings include: A record review of the Clinical Census showed Resident #6 entered the facility on 7/14/26. Resident #6's Minimum Data Set (MDS) assessment remained incomplete. On 7/20/26 at 1:45 PM an observation showed Resident #6 lying in bed on Resident #6's back with eyes closed. A tray table stood next to Resident #6's bed with a lunch tray sitting on top of the table. The food on the lunch tray remained untouched, saran wrap covered the dessert, and silverware remained inside the napkin. A record review of Resident #6's Clinical Record showed Staff A, Certified Nursing Assistant (CNA), documented Resident #6 consumed 75 to 100 percent of the breakfast and noon meal on 7/20/26. On 7/21/26 at 9:20 AM Staff A reported receiving an assignment to the A Hallway on 7/20/26. Staff A stated Staff B, CNA, received an assignment to Resident #6 in the B Hall. Staff A reported Staff B worked a first day at the facility on 7/20/26 and lacked login information to document in the EMR. Staff A reported the Director of Nursing (DON) held awareness and instructed staff to visit the Social Services Director to obtain login information. Staff A reported this occurred between 12:00 PM and 1:00 PM on 7/20/26. Staff A reported not remembering charting Resident #6's breakfast or lunch amounts. Staff A stated when not assigned to a resident, Staff A typically asks the assigned caregiver and charts reported amounts. Staff A stated charting what Staff B reported, noting Staff A didn't see Resident #6's breakfast or lunch tray. On 7/21/26 at 7:50 PM Staff B stated working a first day at the facility on 7/20/26. Staff B stated not giving Resident #6 a lunch tray. When asked about completing charting on 7/20/26, Staff B stated no. Staff B stated receiving login information after lunch. Staff B stated attempting to log in on a computer first, which didn't work, and attempting on a tablet, which didn't work either. When asked about reporting Resident #6's meal intakes to Staff A, Staff B stated no. On 7/23/26 at 8:30 AM the DON reported new staff receive a packet containing login information for the EMR. The DON stated charge nurses can call Information Technology (IT) for login information if needed, noting someone remains available at all times to help obtain login information. The DON stated lacking awareness regarding Staff B's inability to access the EMR to complete charting. The DON stated an expectation for each staff member to complete individual charting rather than having another staff member do it. On 7/27/26 at 8:53 AM the Administrator reported the facility didn't maintain a policy regarding CNA documentation in the EMR.		