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	02/19/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and wound center interview, the facility failed to notify the Physician when a wound VAC, or negative pressure wound therapy (NPWT) (device that uses gentle suction to promote healing in chronic or acute wound) was placed on hold and a previous treatment restarted for 1 of 2 residents reviewed (Resident #2) for pressure ulcers. The facility reported a census of 55 residents.Findings include: Resident #2's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified Resident #2 was dependent on staff with bed mobility, transfers, and toileting. Resident #2's MDS included diagnoses of pressure ulcer of sacral region, stage 4 (dull thickness tissue loss with exposed bone, tendon or muscle). The MDS identified Resident #2 was at risk for developing pressure ulcers and had one stage 4 pressure ulcer. The MDS documented Resident #2 had a pressure reducing device to chair and bed, pressure ulcer/injury care, application of nonsurgical dressing including applications of ointments/medication other than to feet. The Care Plan with a target date of 4/26/26 revealed Resident #2 had an alteration in skin integrity related to morbid obesity, history of transient ischemic attack (TIA) manifested by a sacral wound. The care plan directed staff to administer treatment per physician orders.The Wound Center Discharge Instruction dated 2/2/26 directed staff to start a wound vac to the sacrum wound continuously at 125 mm/hg (millimeters of mercury) pressure and to use black foam when replacing dressing. The instruction sheet documented to continue current treatment until wound vac could be placed. The current treatment order was to moisten ^ strength Dakins on kerlix, squeeze out excess, pack into wound daily and cover with abdominal (ABD) pad one time per day. The February 2026 Treatment Administration record (TAR) documented the wound vac was started on 2/6/26. The February 2026 TAR revealed the wound vac was put on hold beginning 2/13/26 and the treatment for Dakin's moist kerlix packing was restarted daily. Review of the clinical record lacked documentation the Physician and/or the wound center was notified that the wound vac was put on hold and the previous treatment restarted. On 2/17/26 at 9:08 AM, Resident #2 reported he had a large pressure wound to his buttocks. He said it had been the size of his fist and went down to his bone. He said he was supposed to have a wound vac, but it had not been on since last Wednesday as the filter to the machine was on back order. He said the wound was being packed daily. He reported he was not sure if the Wound Center was aware or not that the wound vac was not in place.On 2/18/26 at 10:45 AM, the Director of Nursing (DON) reported the facility was out of wound vac canisters since the end of last week and that the supplies had been ordered. On 2/18/26 at 3:45 PM, the DON reported the Wound Center was not notified that the wound vac was put on hold. She said the facility used an active secondary order for the pressure ulcer treatment. She said the Wound Center probably should have been notified. The DON reported she had checked on supplies, and they were supposed to be arriving tomorrow (2/19/26). On 2/19/26 at 8:17 AM, the Wound Center Registered Nurse (RN) reported the wound center was not aware that Resident #2's wound vac had been put on hold. The Wound Center RN verified the wound center had not received a call regarding the facility being out of canisters. She (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported the wound center would have preferred to be notified when the wound vac was put on hold and the previous treatment restarted. The Wound Center RN reported when the wound vac was ordered, the Dakin's treatment would have been discontinued on their end but if the facility still had the order active on their medication administration record, then the treatment would be appropriate. A facility policy titled Notification for Change of Condition revised 6/2023 documented the facility would provide care to residents and provide notifications of resident change in status.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to report an allegation of potential abuse to the Department of Inspections, Appeals and Licensing (DIAL) for 1 of 14 residents reviewed (Resident #45). The facility reported a census of 55 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #44 revealed a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. The MDS listed diagnoses including Alzheimer's dementia and cerebral vascular accident (stroke). The Care Plan with a target date of 4/262/6 revealed the resident had an activity of daily living (ADL) deficit and required assistance from staff with all ADLs. Review of Progress Notes dated 2/3/26 at 1:44 PM revealed staff observed a bruise to the resident's right eyebrow area that had not been observed on a skin assessment that had been completed that morning. Resident was unable to state how or when the incident occurred. The certified nursing assistant (CNA) had reported the bruise had not been there that morning when cares were completed. Review of facility policy titled, Patient Protection Guidelines Abuse Prevention, Reporting, and Investigation, revised 9/25 revealed the Administrator is responsible for the investigating, reporting, and coordinating of the investigation process of any alleged or suspected abuse regardless of the source of the concern. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Definitions include injury of unknown source- injury should be classified as an injury of unknown source when the source of the injury was not observed by any other person, or the source of the injury could not be explained by the patient, and the injury is suspicious because of the extent of the injury or the location of the injury. During an interview 2/18/26 at 10:45 AM the Administrator revealed they did not report the resident's right eye bruise to DIAL as a family member was adamant that it was unnecessary to report it to the state because they didn't want the state involved. The Administrator added after a discussion with corporate personnel, they completed a facility form titled, Concern Form, instead of notifying DIAL. Review of the Concern Form lacked documentation in the Resolution of Concern section of the form.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to submit a Level 2 Preadmission Screening and Resident Review (PASRR) evaluation for 1 of 2 residents reviewed with a new mental health diagnosis and start of new psychotropic medications (Resident #4). The facility reported a census of 55 residents.Findings include: The Minimum Data Set (MDS) dated [DATE] documented Resident #4 had a Brief Interview for Mental Status (BIMS) of 09 indicating moderately impaired cognition. The MDS revealed Resident #4 had diagnoses of non-Alzheimer's dementia, depression, bipolar disorder, and post-traumatic stress disorder. The Care Plan with a target date of 5/13/26 revealed Resident #4 took an antipsychotic medication for bipolar disorder.The Clinical record revealed Resident #4 had the following diagnosis with effective dates:Major Depressive Disorder - 12/22/25Bipolar Disorder - 1/21/26Post Traumatic Stress Disorder - 9/14/22Adjustment Disorder with mixed anxiety and depressed mood - 9/14/22A Physician Order dated 5/15/25 directed staff to administer aripiprazole (antipsychotic medication) 5 MG (milligrams) one and half tablets daily related to dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. Review of the Clinical Record revealed Resident #4 took aripiprazole since 1/27/25.A Level 1 PASRR completed 1/22/25 documented Resident #4 had a mental health diagnosis of anxiety and depression/depressive disorder. The PASRR evaluation documented Resident #12 received antidepressant medications for depression and antianxiety medication for anxiety. The clinical record revealed no additional PASRR evaluations after 1/22/25.The Clinical record review revealed Resident #12 did not have a Level 2 PASRR evaluation submitted following the new mental health diagnoses of bipolar disorder and with the addition of new antipsychotic medication on 1/27/25. On 2/18/26 at 2:45 PM, the Social Worker reported she submitted a new PASRR on 2/17/26 for review. She said the PASRR came back for a level 2 review onsite. She reported nursing was supposed to tell her when there was a new mental health diagnosis or psychotropic medication so she can update the PASRR. She said there are new management staff, and the information was not communicated to her, so it was missed. On 2/18/25 at 3:46 PM, the Administrator reported the facility did not have a specific policy related to PASSR and that the facility follows the PASRR company's guidelines.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to resubmit a Preadmission and Resident Review (PASRR) evaluation as required for 1 of 2 residents reviewed for PASSR (Resident #35). The facility reported a census of 55 residents. Findings include: Resident #35's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. The MDS included a diagnosis of schizophrenia (psychotic disorder). The clinical record review revealed the resident's Notice PASRR Level II Outcome dated 12/30/25 listed a short-term time limited Level II approval with an end date of 1/29/26. The clinical record lacked evidence that a Level II evaluation had been resubmitted following the short-term end date of 1/29/26.During an interview on 2/18/26 at 2:48 PM Staff E, Social Services, reported she missed the date of 1/29/26 to resubmit the PASSR. Staff E reported she resubmitted the PASSR on 2/18/26 and it came back queued for review. On 2/18/25 at 3:46 PM the Administrator reported the facility didn't have a specific policy related to PASSR and that the facility followed the PASRR company's guidelines.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review and staff interviews, the facility failed to develop a care plan to address risk factors and interventions for 1 out of 14 residents (Resident #3) reviewed for comprehensive care plans. The facility reported a census of 55 residents.Findings include: The Minimum Data Set (MDS) assessment for Resident #3 dated 12/10/25 identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS included diagnoses of heart failure (heart not pumping efficiently) and hypertension (high blood pressure). The MDS documented Resident #3 received an anticoagulant medication during the last 7 days. A Physician order dated 5/19/25 directed staff to administer apixaban (Eliquis) (anticoagulant) 2.5 mg (milligrams) by mouth twice a day for atrial fibrillation.Review of Resident #3's Care Plan with a target date of 3/12/26 revealed the anticoagulant medication, potential side effects and what to monitor for while taking the high-risk medication was not addressed on the Comprehensive Care Plan. On 2/17/26 at 4:10 PM, the Director of Nursing (DON) verified the Care Plan didn't address the anticoagulant medication and it should. On 2/18/26 at 8:45 AM, the Administrator reported the facility didn't have a specific Care Plan policy related to anticoagulants. They expected for the medication be added to the Care Plan within the next care plan review.

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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 observation, clinical record review and staff interviews, the facility failed to follow physician orders related to a wound intervention for 1 of 5 residents reviewed for skin conditions (Resident #45). The facility reports a census of 55 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #45 revealed diagnoses of Alzheimer's disease, stroke and diabetes mellitus (DM). The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) of 4 indicating severe cognitive impairment and received maximal assistance with lower body dressing. Review of the physician orders for the resident revealed an order effective 2/11/26 to cleanse the left foot 2nd and 3rd toes with normal saline, paint with iodine (broad spectrum antibiotic), allow it to dry and to make sure the sock is inside out to prevent rubbing two times a day for wound treatment. The Appointment Note dated 2/12/26 at 4:34 PM indicated Resident #45 returned to the facility after her appointment. Resident #45 returned with papers that directed turn socks inside out to avoid irritation to toes. The Care Plan with a target date of 4/26/26 lacked direction related to the treatment to the resident's left foot 2nd and 3rd toes. On 2/18/26 at 10:09 AM observed Staff A, Registered Nurse (RN), complete Resident #45's treatment to the left foot toes. Staff A removed the resident's tennis shoes prior to the treatment, noted the socks not inside out as ordered. Staff B, Assistant Director of Nursing (ADON), present during the observation and acknowledged Resident #45 didn't have their socks inside out as ordered. Staff B directed Staff A to ensure Resident #45 had their socks inside out when reapplied.

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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 record reviews, staff interviews and policy review, the facility failed to provide adequate nursing supervision to prevent accident and injuries for 1 of 2 residents reviewed (Resident #54) for falls. The facility reported a census of 55 residents. Findings include: Resident #54's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS identified Resident #54 required partial to moderate assistance for all transfers. The MDS included diagnoses of seizure disorder, dislocation of right hip prosthesis, muscle wasting and atrophy of the right thigh (loss of muscle), ataxic gait (unbalanced walking), weakness and other abnormalities of gait and mobility. The Care Plan with a target date of 3/18/26 revealed Resident #54 required assistance with activities of daily living and used a gait belt with transfers. In addition, the care plan documented Resident #54 had a risk for falls with a goal to utilize transfers with a gait belt. The Incident Report (IR) titled Fall, staff assist dated 11/27/25 at 7:15 AM documented a staff member assisted Resident #54 down to the floor. Resident #54 reported he was walking and his legs gave out. The incident reported documented staff assisted Resident #54 to the bathroom from his bed using a walker but no gait belt. The Progress Note titled Incident Report dated 11/27/25 revealed a staff member reported they assisted Resident #54 to the floor while transferring him from his bed to the bathroom as his legs gave out. When the nurse asked the staff member if they had a gait belt on him, they stated they did not because he normally walked okay for them. The note documented they educated the staff member on gait belt usage. On 2/18/26 at 3:35 PM, Staff D, Licensed Practical Nurse (LPN), reported she was the nurse on duty when Resident #54 fell on [DATE]. She said the certified nursing assistant (CNA) didn't use a gait belt at the time of fall. She said she verbally educated the CNA they needed to use a gait belt with all transfers. She said she did not put the education in writing. On 2/18/26 at 3:45 PM, the DON reported she expected the staff to use a gait belt with transfers and ambulation. The facility policy titled Gait Belt revised October 2023 documented the purpose of the policy as to safely and effectively transfer or ambulate a resident.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record review, staff interviews,and resident interview the facility failed to administer oxygen according to physician orders for 1 of 1 resident reviewed (Resident #24) for respiratory services. The facility reported a census of 55 residents. Findings Include: The Minimum Data Set (MDS) assessment for Resident #24 dated 1/16/26 identified a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS included diagnoses of asthma and chronic lung disease. The MDS documented Resident #24 was on oxygen therapy while a resident at the facility. The Care Plan with a target date 4/19/26 revealed Resident #24 had a risk for ineffective breathing patterns related to chronic respiratory failure, emphysema and asthma. The care plan directed to administer oxygen per order. A Physician order dated 7/3/25 directed staff to administer oxygen at 2 liters per nasal cannula (n/c) continuously every shift related to bronchiectasis and asthma. On 2/16/2026 at 11:40 AM, observed Resident #24's oxygen at 0.5 liters per n/c.On 2/17/26 at 1:40 PM, observed Resident #24's oxygen at 0.5 liters per n/c.On 2/17/26 at 1:50 PM, Staff C, Licensed Practical Nurse (LPN) verified Resident #24's oxygen concentrator was set at 0.5 liters. Staff C said she wondered if the concentrator got bumped and nobody noticed. During the observation, Resident #24 reported her oxygen was to be set at 2 liters. On 2/17/25 at 1:55 PM, the Director of Nursing (DON) verified Resident #24's oxygen order was 2 liters continuously. She reported she would expect the physician order to be followed. On 2/17/25 at 2:35 PM, the DON reported the facility did not have a policy on oxygen therapy.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure adequate monitoring of a resident's lab orders to ensure the resident had the correct thickness of their blood to prevent blood clots for 1 of 1 resident reviewed (Resident #2) for blood thinners. Due to the facility's inadequate monitoring of Resident #2's blood work, the physician didn't order a new dose of blood thinner, resulting in them missing a dose of their blood thinner. The facility reported a census of 55 residents.Findings include:Resident #2's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified Resident #2 was dependent on staff with bed mobility, transfers, and toileting. Resident #2's MDS included diagnoses of atrial fibrillation and personal history of other venous thrombosis and embolism (blockage of blood vessels). The MDS identified Resident #2 was taking anticoagulant medication during the last 7 days. The Care Plan with a target date of 4/26/26 revealed Resident #2 took Warfarin and Lovenox (anticoagulant medications) related to venous thrombosis and embolism. The Care Plan directed staff to administer the medications per order. The Progress Note on 1/21/26 documented new orders to increase Warfarin to 5 mg daily and recheck INR on 1/26/26.The Physician Progress Note on 1/22/26 documented Resident #2 restarted on Warfarin and once he was therapeutic the Lovenox would be discontinued. The Physician Progress Note on 1/26/26 revealed an INR result of 1.6 (international normalized ratio) (blood test that measures how long it takes for the blood to clot) and the results were faxed to Provider. The clinical record lacked a response from the Provider on 1/26/26 and 1/27/26. The Progress Note on 1/28/26 revealed Resident #2's Warfarin medication order had dropped off the medication administration record (MAR) and the last dose given was on 1/25/25. The Provider gave orders to put Resident #2 back on the Warfarin 5 mg daily and recheck INR on 2/2/26. Review of the January 2026 MAR directed staff to administer Warfarin 5 mg 1 tablet one time a day with a start date of 1/21/26 and an end date of 1/26/26. The MAR revealed there was not a dose of Warfarin given on 1/27/26.The Hospital Laboratory Form dated 2/9/26 documented an INR result of 1.5. The form was signed by the Provider on 2/10/26 with no directions related to Warfarin medication or when to check the next INR. On 2/18/26 at 9:29 AM, review of Resident #2's Physician orders revealed there was no active order for Warfarin medication. Review of the February 2026 MAR directed staff to administer Warfarin 6 mg 1 tablet on Monday, Tuesday, Wednesday, Thursday and Friday with a start date of 2/9 and end date of 2/16/26. The MAR had an additional order for Warfarin to give 5 mg on Saturday and Sunday with a start date of 2/14/26 and an end date of 2/16/26. The MAR revealed Resident #2 did not receive a dose of Warfarin on 2/17/26.The Progress Note titled Communication with the Physician dated 2/18/26 at 10:16 AM documented a call was placed to the Provider to discuss the recent lab draw on 2/9/26 and Warfarin orders. New orders were received to check INR on 2/18/26 and restart Warfarin at last dosage. The note documented the Warfarin order was to remain indefinite until new/different orders were received from the Provider. On 2/18/26 at 10:45 AM, the Director of Nursing (DON) reported the Physician signed the INR lab result from 2/9/26 but did not provide any new orders and did not address when the next INR was due. The DON reported there was a stop date on the Warfarin order on the MAR for 2/16/26. She said she did not put the physician order in the computer and did not know why there was a stop date. She reported Resident #2 did miss one dose of coumadin on 2/17/26. She said they were going to recheck an INR today and restart the coumadin depending on the INR results. She said the facility would complete a risk management form. The Progress Note titled Incident Report - Medication Event dated 2/18/26 at 1:13 PM documented Warfarin medication order for 6 mg daily Monday through Friday was entered with a stop date of 2/16/26 and the order fell off the MAR as it was completed based on the date. On 2/18/26 at 12:30 PM, the DON reported the stop dates for the Warfarin medication were coming from the Pharmacy as they would only send enough medication until the next INR or maximum of two (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weeks until the INRs were therapeutic and the doses were not changing often. On 2/18/26 at 2:40 PM, the DON reported there were no clarification orders received regarding the INR results on 2/9/26. She said the nurse continued the coumadin orders and put an end date according to how long the pharmacy would send the medication. She reported going forward the Warfarin has been ordered indefinite unless new/different orders were received from the Provider. On 2/18/26 at 8:50 AM, the Administrator reported the facility follows the stand of care for following physician orders.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interviews and clinical record review, the facility failed to start an antibiotic for more than 2 days after a resident received the physician's order for a resident with a urinary tract infection for 1 of 5 residents reviewed (Resident #33) for infection. The facility reported a census of 55.Findings include:The Minimum Data Set (MDS) assessment for Resident #33 dated 1/22/26 identified a Brief Interview for Mental Status (BIMS) score of 00, indicating severely impaired cognition. The MDS identified Resident #33 as dependent on staff for toileting hygiene. The MDS included diagnoses of neurogenic bladder (dysfunction of the bladder caused by nerve damage) and obstructive uropathy (blockage of urine flow). The MDS documented Resident #33 had an indwelling catheter (tube inserted into the bladder to drain urine).The Care Plan with target date of 3/29/26 revealed Resident #33 received antibiotic therapy related to urinary tract infection (UTI). The Care Plan directed staff to administer medications as ordered. The Progress Note dated 1/2/26 at 1:38 PM documented Resident #33's urine as cloudy, dark yellow with thick white mucous like sediment. The noted documented Resident #33 had suprapubic pain with palpation and a functional decline in activities of daily living (ADLs). The facility notified the provider and received a new order to get a urinalysis (UA).The Progress Note dated 1/2/26 at 4:48 PM documented abnormal UA results.The Progress Note dated 1/2/26 at 4:57 PM indicated the facility received a new order from the provider to start Cefadroxil (antibiotic) 500 mg (milligrams) one capsule two times a day for 7 days for a UTI.The Physician order dated 1/2/26 directed staff to administer Cefadroxil 500 mg one capsule two times a day for 7 days for a UTI. The Microbiology Report Preliminary report dated 1/3/26 documented the UA grew out 10,000 - 100,00 cFu/ml (colony-forming units per milliliter) gram negative rods and >100,00 cFu/ml gram negative rods #2 (indicating abnormal results).The Microbiology Report Final Report dated 1/4/26 documented the UA grew out 10,000 - 100,00 cFu/ml klebsiella pneumoniae (gram negative bacteria) and greater than 100,000 cFu/ml proteus mirabilis (gram negative bacteria). The Progress Note dated 1/4/26 documented the facility notified the on-call Provider due to not receiving the antibiotic from the pharmacy. The Provider requested the facility to contact the pharmacy. The note documented the pharmacy was closed and did not have an emergency number. The Progress Note dated 1/5/26 at 12:04 PM documented the facility contact the Pharmacy. The Pharmacy reported they just received the order for the antibiotic and would send out in the evening. The January 2026 Medication Administration Record (MAR) reflected the facility didn't start the antibiotic until the evening of 1/5/26. On 2/18/26 at 6:25 AM, the Director of Nursing (DON) reported the facility had a Pharmacy emergency number for after hours. On 2/18/26 at 7:45 AM, the DON reported the facility had the antibiotic in the emergency kit and the nurse didn't think about taking the antibiotic out of the kit. She said the nurse tried to call the on-call pharmacy number and did not get a response back. She said it was not the first time they didn't receive a call back. On 2/18/26 at 8:30 AM, the DON reported she expected the staff to take the medication from the emergency kit and follow the physician orders. On 2/18/26 at 8:50 AM, the Administrator reported the facility follows the stand of care for following physician orders. On 2/18/26 at 10:44 AM, the Administrator reported the facility did not have a policy or protocol regarding the emergency kit. She reported the facility expected the staff to pull the medication from the emergency kit if available, if the facility didn't receive it from the pharmacy.

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	02/19/2026

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on review of the facility's Quality Assurance Performance Improvement (QAPI) plan, the facility's past surveys, and staff interview, the facility failed to correct their own deficiencies for 5 of 9 areas of concern. The facility reported a census of 55 residents.Findings include:The facility QAPI report, reviewed December 10, 2025, defined the mission as to provide resident-centered healthcare services, excellence in clinical care, and to promote caregiver engagement and empowerment to better serve the resident, family, and the community. The guiding principles included: a. QAPI outcomes are directly related to the quality of care and the quality of life of our residents. b. Our QAPI program focuses on our organization's systems and processes and we strive to continually identify and make changes to our systems/processes in order to improve outcomes.c. Our organization sets goals for performance and measures progress toward those goals. The QAPI program strives to promote safety and high quality throughout clinical interventions and service delivery while emphasizing autonomy, choice, and quality of daily life forresidents and family. The QAPI program will accomplish this by ensuring our data collection tools and monitoring systems are in place and are consistent for proactive analysis, system failure analysis, and corrective action. The facility had the following concerns identified at the current recertification survey that had been cited at previous surveys within the past year:a. Reporting of alleged violations of abuseb. Develop/Implement comprehensive care planc. Services provided meet professional standardsd. Free of accident hazards/supervision/devicese. QAPI program/plan, disclosure/good faith attempt During an interview 2/19/26 at 10:55 AM, the Administrator acknowledged the repeated concerns, stated these are not fully resolved, however the facility is continually working on them. The Administrator advised there is more work to do in QAPI to address these repeat concerns and the facility is building their team.