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	08/11/2022

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 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** 41537 Based on observations, clinical record reviews, facility policy review, staff, and resident interviews the facility failed to reassess 2 of 3 residents (Residents #10 and #15) reviewed for smoking after their initial Smoking Assessment done at admission for safety and interventions when smoking. The facility reported a census of 52 residents. Findings include: On 8/10/22 at 4:15 PM observed Resident #10 and Resident #15 smoking in the facility's designated smoking area without utilizing any smoking safety equipment. 1. Resident #10's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 99, indicating that she could not complete the interview. The Staff Assessment documented the resident had okay long and short-term memory. Resident #10 could make her decisions related to tasks of daily life independently. Resident #10's Smoking assessment dated [DATE] documented the need for a smoking apron to be used when smoking. Resident #10's Care Plan History dated 8/11/22 documented a created date of 5/16/19 for the intervention: It has been determined that Resident #10 required a smoking apron while smoking for safety. The intervention recorded a resolved date of 12/6/19. Resident #10's Progress Notes for the Month of December, 2019 lacked documentation and/or an assessment for the discontinuation of the smoking apron. Resident #10's Assessments tab in the electronic health records (EHR) documented a Smoking Assessment completed on 8/10/22. 2. Resident #15's MDS assessment dated [DATE] identified a BIMS score of 12, indicating moderately impaired cognition. Resident #15's Assessment tab in the EHR indicated the last smoking assessment completed before the survey as 3/13/20. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #15's Assessment tab in the EHR documented a Smoking Assessment completed on 8/10/22, after the start of the survey. The undated Care Plan Focus created on 8/10/22 documented that Resident #15 preferred to use cigarettes. The included interventions indicated the following: a. Resident #15 would not sustain significant smoking related injuries. b. Level of assistance: Resident #15 could smoke on her own without supervision. Resident #15 required assistance going outside at times. Resident #15 required a pendant from the staff before she could go out on her own. c. Mitigation of Risk: Resident #15 required a smoking apron while smoking for safety. d. Mitigation of Risk: Resident #15 used safety gloves to protect her fingertips During an interview on 8/10/22 at 4:00 PM the Director of Nursing (DON) reported that Resident #10 and Resident #15 did not have a completed Smoking Assessment since their initial Smoking Assessment. The DON included that the Smoking Assessments did not have any changes made. Smoking Privileges policy revised 5/13/19 documented the following: 1. If a resident wishes to have smoking privileges, a smoking assessment will be completed and reviewed by the resident and the interdisciplinary team. 2. The smoking assessment will be reviewed approximately annually 12-15 months with a significant change in condition, or at the discretion of the interdisciplinary team. 3. The purpose of the assessment is to identify the level of risk associated with the resident smoking independently and to identify if risk factors can be mitigated with safety interventions including: a. Provision of weather-appropriate outerwear; b. Assistance with exiting/re-entering the building; c. Locked storage for flammable items including matches or flame producing lighter; d. Provision of electronic lighter; e. A non-flammable tray for their wheelchair to set a tabletop ashtray safely; f. Smoke grabbing self-extinguishing ashtray to drop cigarette butts into without extinguishing; g. Use of a smoking apron to protect clothing and other personal items; h. Safety gloves to protect fingertips (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. Direct supervision and/or assistance 4. If safety interventions are indicated, these will be discussed with the resident and outlined within a negotiated risk agreement.

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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 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. 41537 Based on observation, record review, staff and resident interviews and policy review the facility failed to reassess 2 of 3 residents (Resident #10 and #15) for adaptive equipment needed to ensure safety when smoking. The facility reported a census of 52 residents. Findings include During an observation on 08/10/2022 at 04:15 PM of Resident #10 and Resident #15 in the facilities designated smoking area revealed them smoking without any smoking adaptive equipment being used. During an interview on 08/10/22 at 04:00 PM with the Director of Nursing (DON) revealed a Smoking Assessment has not been completed on Resident #10 and Resident #15 since their initial admission Smoking Assessment. She also revealed no changes have been made since then. Record Review on 08/11/22 of Resident #10 Assessments documented a Smoking Assessment completed on 08/10/22. Record Review on 08/11/22 of Resident #15 Assessments documented a Smoking Assessment completed on 08/10/22 with direction to wear a smoking apron. During an observation on 08/11/22 at 01:10 PM of Resident #15 revealed her in the designated smoking section with no smoking apron on. During an interview on 08/11/22 at 10:15 AM with the Director of Nursing (DON) revealed Resident #10 has dropped ashes on her blanket and it has burn holes in it. She also revealed Resident #15 had burn holes on her winter coat and received the burn holes when smoking this past winter. During an interview on 08/11/22 at 10:10 AM with the Administrator revealed Resident #15 had some burn holes from smoking on her blanket this past winter. The Admin returned with a follow up interview on 08/11/22 at 10:40 AM revealing Resident #15 family member contacted the facility to report burn holes on her winter coat this past winter when she was at the facility visiting but he did not see burn holes on the winter coat. During an observation on 08/11/22 at 10:30 AM with the Administrator of Resident #15 closet lacked burn holes on her clothing and unable to locate a winter coat. During an interview on 08/11/22 at 01:10 PM with Resident #15 and Resident #10 revealed they sometimes get ashes on themselves when smoking but just flick them off. Record review of a policy titled Smoking Privileges, revised 05/13/2019 documented the following: 1. If a resident wishes to have smoking privileges, a smoking assessment will be completed and reviewed by the resident and the interdisciplinary team. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The smoking assessment will be reviewed approximately annually 12-15 months with a significant change in condition, or at the discretion of the interdisciplinary team. 3. The purpose of the assessment is to identify the level of risk associated with the resident smoking independently and to identify if risk factors can be mitigated with safety interventions including: a. Provision of weather-appropriate outerwear; b. Assistance with exiting/re-entering the building; c. Locked storage for flammable items including matches or flame producing lighter; d. Provision of electronic lighter; e. Nonflammable tray for wheelchair to set tabletop ashtray safely; f. Smoke grabbing self-extinguishing ashtray to drop cigarette butts into without extinguishing; g. Use of a smoking apron to protect clothing and other personal items; h. Safety gloves to protect fingertips; i. Direct supervision and/or assistance 4. If safety interventions are indicated, these will be discussed with the resident and outlined within a negotiated risk agreement. 5. A staff person will orient the resident to the designated smoking area(s). 6. Portable oxygen is not permitted within the designated smoking area(s). 7. An ashtray will be provided in each designated smoking area. 8. Residents will have a means of alerting staff while outside smoking in the designated area(s).

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on clinical record reviews, facility document reviews, facility policy review, and staff interviews, the facility failed to follow the Centers for Disease Prevention and Control (CD) recommendations related to influenza and pneumococcal vaccinations for one of five residents reviewed (Resident #37). The facility failed to ensure Resident #37 received their Pneumococcal 13-Valent Conjugate (PCV13) and the facility failed to ensure that Resident #37 received an influenza vaccine during the influenza season. The facility identified a census of 52 residents. Findings include: Resident #37's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severe impaired cognition. The MDS included diagnoses of hypertension, chronic obstructive pulmonary disease and atrial fibrillation. The MDS documented Resident #37 did not receive her influenza and/or her pneumococcal vaccine. The MDS indicated that the facility offered and Resident #37 declined to receive the influenza and pneumococcal vaccinations. The Admission / Readmission Nursing Assessment / Baseline Care Plan 0519 assessment dated [DATE] completed by the Director of Nursing (DON) documented Resident #37 did not have a novel Coronavirus 2019 (COVID-19) vaccine. The Assessment failed to assess the vaccination status for influenza or pneumococcal. The electronic health record (EHR) did not note an allergy to the Influenza or Pneumococcal vaccinations. The Admission/Readmission Checklist dated 12/28/21 section labeled Immunizations directed to provide education, obtain consents, and document in the EHR. If the resident has not had a pneumococcal vaccine and is older than 65, we must offer it. Flu shots are to be offered during the months of October - March. The Admission/Readmission Checklist under Immunizations had been initiated. The form included initials indicating completion of the task. Resident #37's Iowa Immunization Registry Information System (IRIS) report documented that she received an influenza booster on 11/3/04 and the Pneumococcal Polysaccharide 23 (PPSV23) on 3/10/20. The IRIS report lacked documentation that Resident #37 received a PCV13 vaccination or an influenza vaccination for the 2021 - 2022 season. A Pneumococcal Vaccination Consent form signed by Resident #37's Power of Attorney over healthcare and finances on 12/28/21 granted permission for her to get the PCV13 vaccination and the influenza vaccination. A review of the EHR progress notes, assessments, miscellaneous documents and the medication administration sheets (MAR)/treatment administration sheets (TAR) from December 2021 thru August 2022 failed to show documentation that Resident #37 had received the PCV13 or the influenza vaccines for the year of 2021-2022. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/11/22 at 7:48 a.m. the Administrator reported that the DON looked and she could not find any additional information regarding Resident #37's vaccinations. He reported that if a resident had a signed consent to receive vaccinations, the facility should have followed up and gave the vaccinations. The Infection Prevention and Control Program (IPCP) Guidelines Policy, revised 11/17, provided by the facility, section labeled Policy documented that through the means of surveillance, investigation, prevention, control, and reporting, the facility maintains an infection control program that helps prevent the development and transmission of communicable diseases and infections and balances precautionary measures with promoting individual resident rights and well-being. The section labeled Guidelines directed the DON or designated person serves as the coordinator of the infection, prevention, and control program and is responsible for oversight and administering of the annual resident influenza vaccination as well as monitoring and administering resident's pneumococcal vaccination. The Influenza and Pneumococcal Pneumonia Vaccines Policy, revised 3/14/20, provided by the facility, documented the following: a. Admission orders should include annual influenza vaccination. The vaccine will be administered on an annual basis, after an assessment for contraindications is completed or resident declines administration of the vaccine. b. The need for pneumococcal vaccination will be assessed upon admission and administered following an order from the medical provider for the type of pneumococcal vaccination needed. c. Residents or their responsible party will receive education regarding the benefits and potential side effects of the immunizations before they are offered the immunizations and there will be documentation of such in the medical record along with consent or declination of vaccination. The Procedure included: 1. Upon admission, determine when the resident last received the influenza and pneumococcal vaccines by assisting the resident/responsible party with completing the Admission Influenza and Pneumococcal Vaccination Information form (page7). a. The resident/responsible party can sign the form indicating preferences to receive or not to receive the pneumococcal vaccines. Provide fact sheets to residents/responsible parties by accessing the Centers for Disease Control website at www.cdc.gov/vaccines vaccine information, scroll about half-way down the page to select specific vaccination. If previously vaccinated with a pneumococcal vaccine, determine if one or both were given and include the date administered if known. If the resident received the pneumococcal vaccine prior to September 2014 then they probably received only the PPSV23 vaccine and will be eligible to receive the PCV 13 vaccine, if desired, once 12 months have passed. b. Record dates of vaccinations in EHR under the Immunization tab. c. Place the Admission Influenza and Pneumococcal Vaccination Information form in the resident's medical record or scan and upload to PCC. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Admission orders should include annual administration of influenza vaccine unless contraindicated. e. The need for pneumococcal vaccination will be assessed upon admission and administered following an order from the medical provider for the type of pneumococcal vaccination needed. 2. Prior to administering the influenza or Pneumococcal vaccines to any resident at any time, provide the resident and/or responsible party with education related to risks/benefits associated with receiving the vaccine(s) and potential side effects. The Procedure proceeded to direct staff to place the education material (benefits of receiving vaccination and potential side effects) sent to the resident/responsible party; and the signed/dated request to receive or deny vaccination for the upcoming flu season in the resident's medical record or scan and upload to PCC. Residents who have refused vaccination in the past should continue to be offered the opportunity to receive vaccination on an annual basis unless contraindicated or allergic. 3. Influenza: a. Residents will be screened to determine eligibility for the influenza vaccination between October 1 and December 31 of each year (residents admitted after that date will be offered influenza immunization through March 31). b. Influenza vaccinations will be administered annually. 4. Pneumonia Vaccines: a. Two pneumococcal pneumonia vaccines - Pneumococcal Polysaccharide (PPSV23) and Pneumococcal 13-Valent Conjugate - also known as Prevnar 13 (PCV13) will be offered to residents who have never received the vaccines or are unsure as to whether they have received the vaccines. b. Pneumococcal pneumonia vaccines can be administered any time of the year. c. PPSV23 should not be administered within 4 weeks of administration of Zostavax. d. PPSV23 - All residents should be offered PPSV23 at age 65. Those who received PPSV23 at or after age [AGE] years should receive only a single dose. ii. Residents between the ages of 19-64 with the following underlying medical conditions or other indications should be considered for administration of PPSV23 (Advisory Committee on Immunization Practices, 2010).

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Perform COVID19 testing on residents and staff. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on review of facility documents, facility policy, and staff interviews the facility failed to follow the Center for Disease Prevention and Control (CDC) guidelines for testing employees twice a week during an outbreak in the facility for 2 of 10 staff (Staff A, Registered Nurse, and Staff B, Certified Nurse Aide) sampled. The facility identified a census of 52 residents. Findings include: During an interview on 8/10/22 at 10:00 a.m. the Administrator reported that the staff are responsible to test themselves for novel Coronavirus 2019 (COVID-19) prior to the start of their shifts. He added that he oversees and verifies that staff completed their testing. He explained that if he noticed on the COVID-19 Test Log that the staff member did not test, then he would go find that employee, have them test, and then sign the COVID-19 Testing Log sheet. During an interview on 8/10/22 at 1:55 p.m. the Director of Nursing (DON) reported the Administrator is responsible for the tracking of staff COVID-19 testing and that he kept the records for the staff COVID-19 testing. During an Infection Control Interview on 8/10/22 at 2:00 p.m. the Administrator reported that one paid nutritional assistant and two certified nurse aides (CNAs) tested positive for COVID-19 on 6/28/22. At that time, the facility implemented staff testing twice a week due to the COVID-19 outbreak. He explained that he checked the Iowa Department of Public Health (IDPH) website on Wednesday mornings each week at a minimum. From there, he goes by the CDC numbers to figure out their weekly community transmission rate. He referred to the IDPH website Community Transmission Information, Novel Coronavirus - COVID-19 Reporting which listed the IDPH website for COVID-19 reporting for positive test rate per 100,000 population by county of residence in the last seven days. The Community Transmission Information documented the numbers listed to determine what level of community transmission your county is in by using the following graphic: (New cases per 100,000 persons in the past 7 days) A. Low <10 B. Moderate 10- 49.99 C. Substantial 50 - 99.99 D. High >100 The Facility Public Posting Notice for cases of COVID-19 in residents and staff, provided by the facility, documented new COVID-19 cases on the following days: 6/27/22, 6/28/22, 6/30/22, 7/2/22, 7/5/22, 7/8/22, and 7/11/22. The facility continued to have current lab confirmed COVID-19 positive cases of staff through 8/8/22 and resident lab confirmed COVID-19 cases through 7/26/22. (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/10/22 the Administrator provided copies of the Daily Huddle meeting forms as documentation of the facilities tracking of weekly COVID-19 community transmission rate tracking. A Daily Huddle meeting form dated 7/18/22 documented under COVID-19 Updates: 8 residents and 4 staff were positive for COVID-19, please test yourself for COVID-19 at least twice a week! The form included documentation under the Employee Announcements high (Community COVID-19) positivity rate. A Daily Huddle meeting form dated 7/26/22 documented under COVID-19 Updates: Positivity rate 129 (indicating high COVID-19 Community Transmission Rate). The Form Under Employee Announcements directed for everybody to please test twice this week. A Daily Huddle meeting form dated 7/27/22 documented under COVID-19 Update: Positivity rate now 203 - very high. A Daily Huddle meeting form dated 8/04/22 documented under COVID-19 Update: Positivity rate at 142 still in the high category. 1. A review of the July 2022 COVID-19 Testing Logs, provided by the facility, documented Staff A, Registered Nurse (RN), signed she had completed her COVID-19 testing on 7/11/22, 7/15/22, 7/19/22, 7/25/22, and 7/29/22. A review of the August 2022 COVID-19 Testing Logs, provided by the facility, documented Staff A had not signed the COVID-19 testing logs to indicate she had completed any COVID-19 testing from 8/1/22 thru 8/10/22. An undated COVID-19 Staff Vaccination Status for Providers Matrix, completed by the facility, documented Staff A did not receive any COVID-19 booster shots. During an interview on 8/10/22 at 3:00 p.m. the Administrator reported that Staff A attends the morning huddle meetings so she would have been expected to sign in and test herself twice a week. The Administrator reviewed the COVID-19 Test Logs that had been provided to the Surveyor from 7/9/22 - 8/8/22. He reported that she tested on [DATE], 7/15/22, 7/19/22, 7/25/22 and 7/28/22. During an interview on 8/10/22 at 3:04 p.m. the DON reported that Staff A had not tested positive for COVID-19 since November 2021. A Punch Detail Report (payroll), dated 7/9/22 - 8/10/22, provided by the facility documented that Staff A worked the following dates and hours in the facility: a. 7/10/22 0.50 hours b. 7/11/22 8.50 hours c. 7/12/22 12/75 hours d. 7/14/22 7.25 hours e. 7/15/22 7.50 hours (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. 7/16/22 4.50 hours g. 7/17/22 2.00 hours h. 7/18/22 6.50 hours i. 7/19/22 6.75 hours j. 7/20/22 7.25 hours k. 7/21/22 7.75 hours l. 7/22/22 7.75 hours m. 7/25/22 7.75 hours n. 7/26/22 8.50 hours o. 7/27/22 7.00 hours p. 7/28/22 7.25 hours q. 7/29/22 8.50 hour r. 8/01/22 8.75 hours s. 8/03/22 5.50 hours t. 8/04/22 7.00 hours u. 8/05/22 4.00 hours 2. A review of the July 2022 COVID-19 Testing Logs, provided by the facility, documented Staff B, Certified Nursing Assistant (CNA), completed her COVID-19 testing on 7/12/22, 7/21/22 and 7/25/22. A review of the August 2022 COVID-19 Testing Logs, provided by the facility indicated that Staff B completed her COVID-19 testing on 8/2/22 and 8/5/22. During an interview on 8/10/22 at approximately 3:10 p.m. the Administrator reported that Staff B had not tested positive for COVID-19 in the past 4 weeks. A Punch Detail Report (Payroll), dated 7/9/22 - 8/10/22, provided by the facility, documented that Staff B worked the following date and hours in the facility: a. 7/10/22 4.50 hours b. 7/11/22 7.50 hours (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. 7/12/22 7.25 hours d. 7/14/22 7.25. hours e. 7/15/22 7.50 hours f. 7/16/22 11.50 hours g. 7/17/22 7.75 hours h. 7/18/22 7.25 hours i. 7/21/22 7.25 hours j. 7/22/22 7.75 hours k. 7/23/22 4.75 hours l. 7/25/22 7.50 hours m. 7/26/22 7.25 hours n. 7/28/22 7.25 hours o. 7/29/22 7.50 hours p. 7/30/22 7.50 hours q. 7/31/22 7.50 hours r. 8/01/22 2.00 hours s. 8/02/22 6.75 hours t. 8/03/22 6.25 hours u. 8/04/22 6.50 hours v. 8/05/22 7.50 hours During an interview on 8/10/22 at 3:15 p.m. the Administrator reported that he looks at the (COVID-19) testing logs daily to oversee if the staff completed their testing as required. If he sees that a staff member has not tested , he will go find the employee, remind them they need to complete the (COVID-19) testing, and sign the testing log. During the interview he stated he thinks the facility needs a new system so they have an easier (COVID-19) log to review. He reported that he expects the staff to test for COVID-19 twice a week or according to the current (CDC) guidelines as directed by the facility. (continued on next page)

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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 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/10/22 at approximately 3:30 p.m. the Administrator clarified that Staff C, Business Office Assistant, tested positive on 7/29/22 and she returned to work on 8/9/22. The facility had no further cases of COVID-19 for the staff after she tested positive. The [Facility ' s] Emergency Preparedness COVID-19 Testing Policy, updated 3/18/22, under the section labeled Definitions, defined an Outbreak as follows: the CDC defines an outbreak as one new COVID-19 infection in any staff or any nursing home-onset COVID-19 infection in a resident. The IDPH defines an outbreak as at least 3 resident cases within the same 14 day period. A resident is any resident living in the nursing facility or skilled nursing facility. Facility staff includes employees, consultants, contractors, volunteers, and caregivers who provide on-site care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions. The Policy section labeled Outbreak states that upon identification of a single new case of COVID-19 in any staff or resident, testing should begin immediately. The Policy directed to perform testing for all residents and health care personnel on the affected unit(s), regardless of vaccination status, immediately but not earlier than 24 hours after the exposure, if known and, if negative 5-7 days later. The CDC COVID-19 Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, updated February 2, 2022 directed the following: Health Care Personnel (HCP) who are up to date (Up-to-Date means a person has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible) may be exempt from expanded screening testing. In nursing homes,the HCP who are not up to date with all recommended COVID-19 vaccine doses should continue expanded screening testing based on the level of community transmission as follows: A. In nursing homes located in counties with substantial to high community transmission, these HCP should have a viral test twice a week. B. If these HCP work infrequently at these facilities, they should ideally be tested within the 3 days before their shift (including the day of the shift). C. In nursing homes located in counties with moderate community transmission, these HCP should have a viral test once a week. D. In nursing homes located in counties with low community transmission, expanded screening testing for asymptomatic HCP, regardless of vaccination status, is not recommended. Per recommendations above, these facilities should prioritize resources to test symptomatic people and all close contacts, as well as be prepared to initiate outbreak response immediately if a nursing home-onset infection is identified among residents or HCP. E. Under New Infection in Healthcare Personnel or Residents, the CDC provides the following guidance: if testing of close contacts reveals additional HCP or residents with SARS-CoV-2 infection, contact tracing should be continued to identify residents with close contact or HCP with higher-risk exposures to the newly identified individual(s) with SARS-CoV-2 infection. A facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility) approach should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. If the outbreak investigation is broadened to either a facility-wide or unit-based approach, follow recommendations below for alternative approaches to individual contact tracing. (continued on next page)

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	08/11/2022

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Southfield Wellness Community	2416 Des Moines Street Webster City, IA 50595

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. Alternative, broad-based approach: If a facility does not have the expertise, resources, or ability to identify all close contacts, they should instead investigate the outbreak at a facility-level or group-level (e.g., unit, floor, or other specific area(s) of the facility). Broader approaches might also be required if the facility is directed to do so by the jurisdiction's public health authority, or in situations where all potential contacts are unable to be identified, are too numerous to manage, or when contact tracing fails to halt transmission. G. Perform testing for all residents and HCP on the affected unit(s), regardless of vaccination status, immediately (but generally not earlier than 24 hours after the exposure, if known) and, if negative, again 5-7 days later.

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on reviews of clinical records, facility documents, facility policy, and staff interviews, the facility failed to address COVID-19 vaccination status for 1 of 5 residents (Resident #37) reviewed. The facility identified a census of 52 residents. Findings include: Resident #37's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severe impaired cognition. The MDS included diagnoses of hypertension, chronic obstructive pulmonary disease and atrial fibrillation. The Admission / Readmission Nursing Assessment / Baseline Care Plan 0519 assessment dated [DATE] completed by the Director of Nursing (DON) documented Resident #37 did not have a novel Coronavirus 2019 (COVID-19) vaccine. Resident #37's Iowa Immunization Registry Information System (IRIS) report identified her as eligible to receive the COVID-19 vaccination. Resident #37's electronic health record (E.H.R.) lacked documentation she or her representative received education regarding the COVID-19 vaccination. Resident #37 ' s E.H.R. and paper clinical record lacked documentation of an administration of a COVID-19 vaccination. During an interview on 8/11/22 at 7:48 a.m. the Administrator reported the Director of Nursing (DON) had not been able to find any additional information pertaining to Resident #37's vaccination status. During an interview on 8/11/22 at 8:35 p.m. the Administrator reported the Resident's Power of Attorney is very difficult to approach on the subject of COVID-19 vaccination and stated he had approached several times, but acknowledged the lack of documentation in the medical record. The Vaccine Policy Coronavirus (COVID-19), updated 8/11/21, provided by the facility directed the following: 1. Residents will be screened and offered COVID-19 vaccination when available to the facility unless medically contraindicated or the individual is already vaccinated. The Policy directed individuals should be offered a vaccination regardless of history of symptomatic or asymptomatic COVID-19. 2. Residents may be screened to determine eligibility for vaccination with COVID-19 vaccine as part of the admission/readmission process, during completion of the annual MDS, and after review of facility vaccination rates that may impact visitation status. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The Centers for Disease Control (CDC) and the Advisory Committee on Immunization Practices (APIC) have determined COVID-19 vaccines are safe and effective and that individuals eligible should get a COVID-19 vaccine as soon as they can. 4. The Infection Preventionist will provide education regarding the benefits and potential side effects of the immunization before offering the immunization and will retain evidence of this in the medical record along with consent or declination of vaccination. 5. The resident or responsible party has the right to accept or decline the COVID-19 vaccination and to change their mind to receive the vaccination at any point in time. The Facility should not interfere, coerce, discriminate, or retaliate against a resident for exercising the right to refuse vaccination; however, facility staff should document the refusal and continue to provide and document education provided to the resident as to the risks/benefits and potential adverse effects from receiving vaccination. The Policy goes on to direct the COVID-19 Vaccination is currently recommended for everyone [AGE] years of age or older. There are currently three different COVID-19 vaccinations approved by the Food and Drug Administration (FDA) via an Emergency Use Authorization.