STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165557	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deerfield Health Care Center	13731 Hickman Road Urbandale, IA 50323

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 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. Based on clinical record review, hospital record review, internal incident investigation documentation, family and staff interviews, the facility failed to adapt safety interventions in response to cognitive changes for 1 of 3 residents reviewed for falls (Res #1). The facility reported a census of 23 residents. Findings include:The Minimum Data Set (MDS) of Res #1 dated 9/11/25 identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment (possible score of 0-15).The MDS of Res #1 dated 12/10/25 identified a BIMS score of 11/15.The MDS of Res #1 dated 3/10/26 identified a BIMS score of 10/15, a continued trend of lower scoring, indicating worsening cognitive impairment.The Comprehensive Care Plan of Res #1 identified a Focus Area of Impaired Cognitive Function or Impaired Thought Process, dated 10/13/25. The Care Plan directed staff to monitor/document/report any changes in cognitive function. The Care Plan identified a Focus Area of Activities of Daily Living (ADL) performance deficit, dated 9/5/25 with a revision date of 9/26/25. On 9/26/25 the Transfer assistance intervention was documented as using a Stand Aid (non mechanical lift) with one staff member assistance. On 4/23/26, the intervention changed to direct staff to use two staff member assistance using the EZ stand (stand up mechanical lift). On 6/11/26, the Care Plan was updated to two staff assistance with Hoyer (full body mechanical lift). And on 6/15/26, the Care Plan was updated to include ?Lift Recliner - Supervision/Assist'. Prior to the 6/15/26 notation, the Care Plan failed to address the fact that the resident had a lift recliner. A nursing note dated 5/31/26 documented a Certified Nurse Aide (CNA) had responded to Res #1's call light and the resident was found on the floor. After staff positioned the resident onto her back, a deep laceration on her forehead and a second laceration on the bridge of her nose were seen. Emergency services were called as well as the resident's daughter and the resident was sent to the Emergency Room. The note documented emergency services stabilized the resident placing a c-collar (cervical collar - a medical device worn around the neck to support the spinal cord, restrict head movement, and immobilize the cervical vertebrae) on her and used a backboard (a rigid, flat device used by emergency responders to immobilize a patient's spine during transport) to transfer her onto a gurney.The Investigation Summary provided by the facility documented a CNA entered the room of Res #1 approximately two minutes after the resident had pushed her call light. The CNA found the resident on the floor in front of her recliner and summoned the nurse for assistance. The nurse noted the resident was lying face down on her right side with her head against her nightstand. The Summary detailed the resident's lift chair/recliner was noted to be in an elevated position and that the resident was in control of her lift chair remote and able to operate it independently. The Summary stated it appeared as if the resident may have slid out of the elevated lift chair and hit her head on the nightstand as she fell to the ground.Resident #1 underwent a computed tomography (CT) scan at the hospital (a diagnostic scan to see detailed images of bones, organs, soft tissues). The CT scan of the cervical spine indicated an acute fracture was found of the C1 vertebra (the topmost bone in the spine located at the base of the skull). On 6/30/26 at 4:30 pm, the Director of Nursing (DON) stated no safety assessment for Res. #1's use of her lift recliner had been done as there had been no reason to. She stated there was no indication she was unsafe as she was able to control her chair remote, her tv remote and her phone. On 7/1/26 at 9:09 am, the Administrator stated quarterly nursing assessments (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

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He described he had noted some cognitive changes over the last few months, remembering specifically the day prior to her fall, she was very confused that day and he had reported it to her daughter but then the resident snapped out of it. He stated he did not witness the resident using her chair in an unsafe manner or have any safety concerns with the chair prior to her falling. On 7/1/26 at 4:10 pm, Staff I, CNA stated she worked the overnight shift several times a week for the last several years on the hall Res #1 resided on. She recalled the resident was initially able to use a stand aide and then declined to use the EZ stand. She reported the resident did have some confusion on her shifts and recalled when she was talking about having people over, describing a lot of people in her room, seeing things that were not there. She stated she would talk about needing to go upstairs, but then her confusion would clear up later and these episodes were on and off. She said if the resident was in the chair on her shift (she sometimes comes in at 6:00 pm rather than 10:00 pm) she would place the remote to the resident's chair in the pocket of the chair and give the resident the TV remote and her phone. She stated at times the remotes would confuse her but she was normally able to use the TV remote by herself. Staff I said the staff put the remote to the chair where the resident could not reach it. She stated at times when she would first come to work for the night shift, she would receive reports from off going staff of the resident raising her lift chair and staff putting it back down but stated the majority of the time she worked with her, the resident was already in bed when she arrived. On 7/2/26 at 8:00 am, the Medical Director recalled the episode in March of 2026 of when Res #1 had the twitching and she was not acting herself. He stated an antidepressant dosage had been raised and he lowered the dose back down and she appeared to improve after that. He felt when he saw her again in May of 2026, she was more at her baseline but did describe that her baseline was that she did have a cognitive deficit and recalled her BIMs scores declining. He said when he saw her in March, she was especially not her normal self. He was not aware of any issues with her lift chair and believed she had the chair for as long as she had resided at the facility. On 7/2/26 at 12:46 pm, Staff J, CNA stated she was a relatively new employee and had worked at the facility approximately 3 months. She said she did not know Res #1 well as she generally worked on the other side of the building. She confirmed she had cared for Res #1 on the day shift on 5/31/26. She stated she had no concerns that day and detailed that after lunch, Res #1 was assisted back to her recliner and she didn't notice anything out of the ordinary with her. She described that she had reclined the resident all the way back so she was comfortable and could rest and placed the remote to the chair in the chair pocket. She stated Staff K, CNA was the staff member who found the resident after her fall. On 7/2/26 at 12:57 pm Staff K, CNA said she had worked at the facility since October of 2025 and floated back and forth between the two halls. She felt she knew Res #1 pretty well. On the day of the fall, she stated she had just gotten onto the floor, clocking in at 2:00 pm. She stated Res #1's call light went off which was odd as the resident rarely rang for help that time of day. She said as she began to enter her room, she spoke Res #1's name to ask her what she needed but as she entered further she saw her on the floor. She described as she approached the resident, she saw blood on the carpet and then ran to get the nurse. She voiced that the normal routine of Res #1 was to be napping at that time of day. She stated staff normally placed the chair remote in the pocket of the recliner for the resident to reach for if needed. She said when she found the resident on the floor, the remote was dangling to the floor from the chair. (continued on next page)

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