STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165381	A. Building B. Wing	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stone Cottage Care Center	900 South Stone Street Sigourney, IA 52591

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Based on observation, clinical record review, and staff and resident responsible party interviews, the facility failed to provide adequate supervision and staff assistance to residents to prevent injuries from falls, for 1 of 4 residents with fall histories reviewed (Resident #4). The facility's failure to provide the appropriate supervision and assistance resulted in Resident #4's hospitalization in a hospital Intensive Care Unit with injuries that included hemothorax, fractured 6th through 10th right ribs, displaced right shoulder and compression fracture of the 10th thoracic vertebrae that resulted from an unwitnessed fall. The facility reported a census of 34 residents. Findings include:The 9/13/25 modified Minimum Data Set (MDS) Assessment revealed Resident #4 had diagnoses that included repeated falls, Wernicke's encephalopathy (a severe neuropsychiatric disorder caused by thiamine deficiency), alcohol dependence with withdrawal delirium, arthritis, irritability and anger, scored 8 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment that indicated severe cognitive impairment, with symptoms of delirium present. The Assessment revealed the resident required moderate staff assistance for toilet transfers, personal hygiene and to don or doff shoes, able to ambulate independently with walker or cane used, and had 1 fall with major injury since the previous assessment completed on 8/16/25. Resident #4's Fall Risk Assessments revealed the following scores; a score of 10 or greater indicated the resident at high risk for falls:6/10/25 score 10.06/25/25 score 11.0 7/8/25 score 11.0 8/16/25 score 11.08/30/25 score 17.09/13/25 score 17.010/1/25 score 15.010/9/25 score 13.010/14/25 score 14.010/16/25 score 13.0 The required quarterly care conferences documented in the resident's record revealed they were completed on 10/3/24, 2/20/25, 5/23/25, 8/26/25 and 9/23/25, and did not include his family or legal representative/power of attorney (POA) as required. The resident's Nursing Care Plan included the following problems and associated interventions:1. Risk for injury related to poor safety awareness as evidence by disregard for physical limitations or unsafe behaviors, initiated 7/29/2025. Goal with target date 12/22/25: Resident will remain free from injury, revised 9/25/2025. Interventions included: Staff will implement consistent safety interventions to reduce risk, initiated 7/29/2025, revised 9/25/2025. Document all safety behaviors and interventions, initiated 7/29/2025.Educate patient about safety risks and calling for help, initiated 7/29/2025. Initiate regular safety rounding, initiated 7/29/2025. Keep call light and frequently used items within reach, initiated 7/29/2025. Perform cognitive assessment frequently, initiated 7/29/2025. 2. Resident is at risk for falls related to psychoactive drug use, initiated 7/9/24, revised 1/22/2025. Goal with target date 9/22/25: Resident will be free of falls through the review date. Interventions included:Encourage resident to allow staff to pick items up off of the floor for him. He often prefers to do things himself despite the safety risks, initiated 12/30/2024. Be sure resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, initiated: 7/9/2024. Ensure a safe environment that is free of clutter and has adequate lighting. Clean up spills promptly, initiated 7/9/2024. Resident prefers to wear gripper socks in facility, and not shoes, initiated 9/9/2024. PT/OT (Physical Therapy/Occupational Therapy) to eval and treat, initiated 1/24/2025. OT eval and treat related to fall 6/2/25 to aid in strengthening, initiated 6/2/2025.Sign placed in room to encourage resident to call for help making his bed, initiated 4/12/2025.Tape added to feet of dining room chair to help grip the floor; Yellow tape to mark his dining room chair, initiated 1/24/2025. 3. Resident has potential to demonstrate behaviors and/or experience a fall after events such as: Dr. appointments, facility gatherings, family visits, initiated 8/11/2025. Goal with target date 9/22/25: Resident will demonstrate effective coping skills through the review date, and goal with target date 9/22/25: Resident will not harm self or others through the review date. Interventions included: When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later, initiated 8/11/2025. 4. The resident had an actual fall 6/10/25, 6/25/25, 6/30/25, 7/3/25, 7/8/25, 7/28/25, 8/16/25, 8/18/25, 8/21/25, 8/30/25, 9/1/25, 9/2/25, 9/30/25, 10/22/25, initiated 7/2/25, last revised 11/4/25. Goal with target date 9/22/25: Resident will have no injuries from falls through next review. Interventions included:Encourage resident to keep his door open when in his room, initiated 10/1/2025. Encourage resident to use safe transferring techniques when getting out of dining room chair, initiated 7/2/2025.Resident uses the same dining room chair, indicated by name tag on the back of the chair, initiated 7/2/2025.Medication Evaluation due to recent fall. Resident has had increased behaviors due to Hospital removing routine medication, initiated 8/30/2025. Night light in resident's room, initiated 7/24/2025. Observe