

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165381	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2025
NAME OF PROVIDER OR SUPPLIER Stone Cottage Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, record review, and facility policy review. The facility failed to provide 2 of 2 residents (Resident #2 and Resident #5) reviewed for accommodation of needs, with an effective call light system to meet the needs of residents who have both upper and lower extremity impairments. The facility reported a census of 32 residents. Findings include: 1. Review of the admission Minimum Data Set (MDS) assessment, dated 12/04/25, revealed that Resident #2 admitted to the facility on [DATE] from another Nursing Home. Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. The list of diagnoses included quadriplegia (loss of movement and sensation, affecting all four limbs and torso) and Diabetes Mellitus. The MDS identified that Resident #2 had been dependent on staff assistance for all care tasks, hygiene tasks, and for all mobility. Resident #2 had an indwelling urinary catheter and was always incontinent (unable to control) both bowel and bladder functions. Review of an admission assessment, dated 11/26/25, revealed that Resident #2 was unable to use the following listed devices: Nursing call bell; Bed controls; Side rails; TV; Telephone. The assessment documented that Resident #2 uses a cell phone to call the facility. Review of the Care Plan, date initiated 12/17/25, revealed a Focus area for activities of daily living (ADL) self care performance deficit, related to disease process (quadriplegia) and identified that Resident #2 required total dependence on staff assistance for toilet hygiene, bed mobility, bathing, oral care, personal hygiene, dressing, eating, and transferring. Review of the Care Plan, date initiated on 12/02/25 and revised on 12/17/25, revealed a Focus area for Resident #2 exhibiting verbal aggression towards staff, including yelling and name-calling, and reports dissatisfaction with call light system and perceived unmet care needs, with the goal that Resident #2 would feel heard and supported and will communicate concerns in a calm manner with more than or equal to 75% of interactions. The Care Plan listed interventions, included the following, in part: Approach Resident #2 calmly using non-confrontational tone and trauma informed communication. Date initiated: 12/02/25. Date revised: 12/17/25. Document all cares provided at the time they are completed. Date initiated: 12/02/25. Ensure two staff persons are present during care interactions or room entry as needed. Date initiated: 12/02/25. Validate Resident #2's concerns and provide reassurance regarding response time and safety. Date initiated: 12/02/25. Date revised: 12/17/25. During an interview on 12/18/25 at 2:35 PM, Resident #2 stated that during his first 8 days at the facility, he had to use his cell phone as a call light. Resident #2 reported that he had come from another facility where he could use a breath-activated call light system and when requested to use this, the facility notified him that the call light system would not be compatible with his breath-activated call light. Resident #2 reported difficulty with using his cell phone for a call light due to the cell phone not being charged or within reach for him to use when he needed help. Resident #2 stated after 8 days using his cell phone for a call light, the facility provided him with a motion sensor door bell system that was observed to be present on an overbed table next to the bed during the interview. Resident #2 demonstrated the use of the motion sensor by waving his right hand near the sensor until a red light appeared. Resident #2 stated his understanding of the door bell system was that it would ring once and sound like a church bell near the dining room/common area. Resident #2 voiced concern that staff did not hear the doorbell when activated if they were in other resident rooms or away from the common area. Resident #2 reported the following dates and times he kept documented on cell phone, in which the motion sensor doorbell had not been answered in a timely manner: On 12/08/25 at 7:00 AM, the call system was activated with no response, at 7:20 AM the call system was again activated with no response, and at 7:40 AM the call system was again activated with no response. Resident #2 stated he received assistance at 8:11 AM. On 12/09/25 at 6:00 AM, the call system was activated with no staff response until 7:00 AM. On 12/11/25 at 6:20 PM, the call system was activated with no staff response until 7:05 PM. On 12/12/25 at 11:00 AM, the call system was activated with no staff response until 11:45 AM. On 12/15/25 at 10:30 AM, the call system was activated with no staff response until 12:00 PM. During an interview on 12/22/25 at 11:30 AM, Staff A, Registered Nurse (RN), reported concern with staffing due to a high acuity of residents who required 2 staff assistance, total dependence on staff for ADLs, and had behavioral/mental health diagnoses. Staff A stated that call lights are not able to be answered in a timely manner and stated he had observed times in which it would take greater than 30 minutes for staff to be able to answer a call light. Staff A confirmed that Resident #2 used his cell phone as a call light when first admitted to the facility, but that the</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observations, staff and resident interview, clinical record review, and facility policy review the facility failed to answer resident call lights in a timely manner for 1 of 3 residents (Resident #2) reviewed for call lights, when the resident reported waiting for assistance took greater than 15 minutes. The facility reported a census of 32 residents. Findings include: Review of the Minimum Data Set (MDS) assessment, dated 12/04/25, revealed that Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. The list of diagnoses included quadriplegia (loss of movement and sensation, affecting all four limbs and torso) and Diabetes Mellitus. The MDS identified that Resident #2 had been dependent on staff assistance for all care tasks, hygiene tasks, and for all mobility. Resident #2 had an indwelling urinary catheter and was always incontinent (unable to control) both bowel and bladder functions. Review of the Care Plan, date initiated 12/17/25, revealed a Focus area for activities of daily living (ADL) self care performance deficit, related to disease process (quadriplegia) and identified that Resident #2 required total dependence on staff assistance for toilet hygiene, bed mobility, bathing, oral care, personal hygiene, dressing, eating, and transferring. Review of the Care Plan, date initiated on 12/02/25 and revised on 12/17/25, revealed a Focus area for Resident #2 exhibiting verbal aggression towards staff, including yelling and name-calling, and reports dissatisfaction with call light system and perceived unmet care needs, with the goal that Resident #2 would feel heard and supported and will communicate concerns in a calm manner with more than or equal to 75% of interactions. The Care Plan listed interventions, included the following, in part: Approach Resident #2 calmly using non-confrontational tone and trauma informed communication. Date initiated: 12/02/25. Date revised: 12/17/25. Document all cares provided at the time they are completed. Date initiated: 12/02/25. Ensure two staff persons are present during care interactions or room entry as needed. Date initiated: 12/02/25. Validate Resident #2's concerns and provide reassurance regarding response time and safety. Date initiated: 12/02/25. Date revised: 12/17/25. During an observation on 12/18/25 at 2:35 PM, Resident #2 demonstrated the use of the motion sensor call light system, which the facility provided him. The motion sensor was observed on top of an overbed table next to the bed. Resident #2 waved his right hand near the sensor until a red light appeared to activate a bell to sound near the dining room/resident common area. At 3:20 PM, no staff had entered Resident #2's room to answer the activated motion sensor call system. During an interview on 12/18/25 at 2:35 PM, Resident #2 stated that during his first 8 days at the facility, he had to use his cell phone as a call light. Resident #2 reported that he had come from another facility where he could use a breath-activated call light system and when requested to use this, the facility notified him that the call light system would not be compatible with his breath-activated call light. Resident #2 reported difficulty with using his cell phone for a call light due to the cell phone not being charged or within reach for him to use when he needed help. Resident #2 stated after 8 days using his cell phone for a call light, the facility provided him with a motion sensor door bell system. Resident #2 stated his understanding of the door bell system was that it would ring once and sound like a church bell near the dining room/common area. Resident #2 voiced concern that staff did not hear the doorbell when activated if they were in other resident rooms or away from the common area. Resident #2 reported the following dates and times he kept documented on cell phone, in which the motion sensor doorbell had not been answered in a timely manner: On 12/08/25 at 7:00 AM, the call system was activated with no response, at 7:20 AM the call system was again activated with no response, and at 7:40 AM the call system was again activated with no response. Resident #2 stated he received assistance at 8:11 AM. On 12/09/25 at 6:00 AM, the call system was activated with no staff response until 7:00 AM. On 12/11/25 at 6:20 PM, the call system was activated with no staff response until 7:05 PM. On 12/12/25 at 11:00 AM, the call system was activated with no staff response until 11:45 AM. On 12/15/25 at 10:30 AM, the call system was activated with no staff response until 12:00 PM. During an observation on 12/22/25 at 8:48 AM, a church bell sound heard near the dining room, the bell chimed one time. No staff present in the area, staff were noted to be in other resident rooms. At 9:00 AM a higher pitched bell sound heard near the dining room, this bell chimed one time. At 9:09 AM 2 Certified Nursing Assistant (CNA) staff sat at a table in the dining room with a laptop computer and at 9:15 AM, no staff had entered Resident #2's room following activation of the doorbell call system. During an interview on 12/22/25 at 11:30 AM, Staff A, Registered Nurse (RN), reported concern with staffing due to a high acuity of residents who required 2 staff assistance, total dependence on staff for ADLs, and had behavioral/mental health diagnoses. Staff A stated that call lights are not able to be answered in a timely manner and stated he</p>		