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	05/28/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interviews, the facility failed to maintain the dignity for one of three residents reviewed (Resident #8) when they failed to ensure to keep him from sitting in his own stool for hours before staff provided incontinence cares and failed to treat him with dignity and respect by using profanity. The facility reported a census of 35 residents. Findings include:The Minimum Data Set (MDS) dated [DATE] identified Resident #8 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 and had the following diagnoses: Traumatic Spinal Cord Dysfunction, Quadriplegia, Neurogenic Bladder and Diabetes Mellitus. The MDS also identified Resident #8 to be totally dependent on staff for assistance with all activities of daily living which included personal hygiene, dressing, eating, transfer from chair to bed. The MDS documented that the resident had an indwelling urinary catheter. On 5/14/26, the Care Plan identified Resident #8 with the problem of falsely accusing the staff of excessive call light wait times and directed staff to respond to call lights promptly and acknowledge resident's concerns respectfully. Approach the resident calmly using non-confrontational tone and trauma-informed communication. In an observation and interview on 5/20/26 at 11:30 AM Resident #8 sat up in bed wearing a hospital gown with red stains near neckline. The suprapubic catheter was connected to a drainage bag in a dignity bag below the bladder level. He stated he did not have a pressure ulcer, but when he had to sit 1.5 hours in his stool, this makes him very angry, makes him feel embarrassed, and his dignity is pretty much stripped from him. In an interview on 5/20/26 at 2:46 PM, Staff K, CNA reported last month, she came to Resident #8's room to help with wound are. He then asked why the Director of Nursing (DON) was in his room that he did not want her there. She heard the DON tell Resident #8 that he was an alcoholic narcissist and if he didn't like it he could f___ing leave. In an interview on 5/21/26 at 2:53 PM, Resident #8 reported the DON asked why he told the hospital they refused occupational therapy. Her tone was angry and visibly upset. It was not a pleasant exchange, it was accusatory and angry. This made him feel upset because he never said anything like that, it just confirms that the DON does not like him and she hates him. Resident #8 stated the DON has treated him like this the first month he was here. Resident#8 reported there were so many instances where he would sit in his feces for over an hour not once, but many times. In an interview on 5/26/26/ at 1:03 PM, Staff B, RN reported Resident #8 informed her that last month, the Director of Nursing told him that if he did not like it here, he can f___g leave. The DON also said he was a narcissistic alcoholic. In an interview on 5/29/26 at 7:55 AM, the Director of Nursing reported when asked about the interaction she had with Resident #8 where he reported she called him a narcissistic alcoholic a__hole and that if he didn't like it here, he could f___g leave. She reported she did not use those words toward him, that she was clarifying those the words his ex-spouse had used. The Facility Policy titled: Quality of Life: Dignity, dated as last revised on August 2009 had documentation of the following:Residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc.).Staff shall speak respectfully to residents at (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs.Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by promptly responding to the resident's requests.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interview, the facility failed to provide oral cares to one of three residents reviewed (Resident #6) and failed to provide peri cares for one of three residents reviewed (Resident #8). The facility reported a census of 35 residents.Findings include:1. The Minimum Data Set (MDS) Assessment tool with reference date 2/19/26 revealed Resident #6 admitted to the facility 11/14/25 with diagnoses that included quadriplegia, seizure disorder, anxiety, depression, asthma, skin graft failure and stage 4 pressure ulcer, scored 15 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment, that indicated intact cognition and without symptoms of delirium present, always able to make himself understood and always able to understand others. The assessment revealed the resident had deficits of bilateral upper and lower extremities, totally dependent on staff assistance for all cares that included repositioning in bed, transfers to and from bed or chair, bathing, dressing, eating, toileting and personal hygiene, the resident unable to stand or ambulate. The Nursing Care Plan included a problem labeled (Resident's name redacted) requires total assistance with activities of daily living due to impaired mobility related to quadriplegia. (Resident's name redacted) has a history of expressing inaccurate or inconsistent statements regarding care interactions, creating potential risk for misinterpretation and emotional distress for both the resident and staff. initiated 11/24/25, with 6/5/26 goal: (Resident's name redacted) will remain free from physical injury, psychological harm, and perceived or actual care concerns through consistent use of two-person assistance and clear communication strategies. The Nursing Care Plan directed staff to provided care that included: 1. Explain each step before and during hands-on care. 2. Offer choices when possible. 3. Maintain privacy (doors closed, curtains pulled). 4. Provide cares in pairs for all personal care tasks including: transfers, hygiene and peri-care, dressing, bed mobility, bed bath and repositioning. 5. Validate concerns without arguing or escalating. 6. Reinforce expectations and boundaries respectfully. 7. Avoid defensiveness if reports are made, respond per policy. Another problem labeled as (Resident's name redacted) has actual impairment to skin integrity related to quadriplegic status, dependent for all cares and repositioning unstageable right heel pressure wound initiated 2/19/26, with 6/5/26 goal: (Resident's name redacted will have no complications related to skin impairment. The Nursing Care Plan directed staff with interventions that included: 1. Encourage adequate nutrition and hydration, collaborating with dietary services as appropriate to support skin integrity and wound healing. 2. Keep skin clean and dry, providing hygiene and incontinence care as needed to prevent (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	moisture-related skin breakdown. 3. Offload pressure from the left heel by floating heels on pillows while resident in bed to reduce pressure and promote healing. 4. Reposition resident routinely according to facility protocol and resident's tolerance to prevent prolonged pressure on the affected area. Observations revealed: 5/21/26 at 9:48 a.m., Resident positioned on his back, in bed with feet/heels floated on a pillow. Cell phone used as his call light positioned on his chest area with his hand next to the phone, teeth had visible food residue on the frontal surface of upper and lower teeth. 5/26/26 at 2:28 p.m. Resident mouth dry, teeth with visible residue/film on frontal surface of upper and lower teeth. Resident in bed, on back, feet on pillow, cell phone on his chest area. Resident interviews revealed: During an interview 5/21/26 at 9:48 a.m., the resident stated he was dependent on staff for all care due to quadriplegia. He usually had to ask for care that he required, such as oral care, repositioning and getting a drink. He had not had his teeth brushed since the evening of 5/18/26. They discussed his care needs at a recent care conference and staff were supposed to brush his teeth and provide oral care every evening. The resident had to use his cell [NAME] to call when he required assistance, he used [NAME] to voice activate his cell phone to call the facility to elicit a staff response. 5/26/26 at 2:28 p.m. the resident stated the last time he had oral care was Thursday and Friday evenings, 5/21/26 and 5/22/26. Staff interviews revealed: 5/26/26 at 3:10 p.m. Staff D, CNA stated they were supposed to provide residents with oral hygiene care/brush teeth at least once a shift or as directed on the Kardex. Staff were supposed to reposition residents that couldn't position themself at least every 2 hours, or as directed. 5/27/26 at 1:15 p.m. Staff K, CNA stated she did oral care on the resident yesterday morning, used a toothette and that's normally how she provided the care. When asked how often he was supposed to have oral hygiene care/teeth brushed she stated she wasn't sure. Staff K looked in the Kardex at that time, the care plan said staff were supposed to brush his teeth daily in the evening. 5/28/26 at 8:26 a.m. the Director of Nursing (DON) stated she would expect staff to follow the care plan/Kardex for resident care including oral hygiene, they'd just had a care conference for the resident, she'd updated his care plan and staff were directed to brush teeth/provide oral care daily in the evening. When asked about the resident having to request the care, that staff didn't provide the care routinely the DON stated the resident liked to stay up later in the evening and would call the facility with his cell phone when he was ready to lay down, that is when staff would do the care. The Administrator was interviewed 5/28/26 at 9:15 a.m. stated she would want her teeth brushed (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after a meal, expected staff to provide the care at least in the morning and evening, or as directed on their care plan or per their request. When asked why the resident's oral care was not done as directed on his care plan the Administrator stated there shouldn't be any reason why it wasn't done, it's addressed on the all the Kardex which all the staff had access to. 2. The Minimum Data Set (MDS) dated [DATE] identified Resident #8 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 and had the following diagnoses: Traumatic Spinal Cord Dysfunction, Quadriplegia, Neurogenic Bladder and Diabetes Mellitus. The MDS also identified Resident #8 to be totally dependent on staff for assistance with all activities of daily living, which included personal hygiene, and had an indwelling urinary catheter. On 3/4/26, the Care Plan identified Resident #8 with the problem of verbalizing concerns that staff are not completing cares and directed staff to document care provided in the log when entering the room per plan of care. A review of the Interdisciplinary Team Progress Note dated 5/22/26 at 4:11 PM, had documentation that staff documentation should reflect ongoing peri-care assistance provided by staff, including resident-maintained signature logs documenting staff assistance during care episodes. Resident had been educated on what peri-care entails. Multiple peri-care audits completed by nursing management. The facility did not provide documentation to show peri care audits had been completed. A review of the notebook where staff documented dates times and cares provided revealed no peri care documented on May 14, 15, 16, 17, 18, 19, 20, 2026. In an observation and interview on 5/20/26 at 11:30 AM Resident #8 sat up in bed wearing a hospital gown with red stains near neckline. The suprapubic catheter was connected to a drainage bag in a dignity bag below the bladder level. He reported he usually gets peri care once a shift. He had peri care done at today at 5:00 AM, however, prior to that he did not have peri care for five days. The area to his groins and scrotum appear reddened. In an interview on 5/21/26 at 2:53 PM, Resident #8 reported the last time he got peri care was yesterday at 5:00 AM. They cleaned around his supra pubic catheter area, but no one touched his groin area. In an interview on 5/26/26/ at 1:03 PM, Staff B, RN reported Resident #8 told her that he had not received peri care in the last 5 days. In an interview on 5/26/26 at 12:18 PM, Staff C, CNA reported Resident #8 told her that he had not received peri care in the last 5 days. In an interview on 5/26/26 at 1:58 PM, Staff A, CNA reported Resident #8 should get baths 3 times a week and he has reported he does not get them on Fridays when Staff A is off. She could not explain why this was not getting done. Resident #8 also reported he did not have peri care in 5 days and said he should not have to ask, that should be that part of his care. She also reported Resident #6 also complained that last Friday he did not get a shower. He did say he filed a grievance about that. In an interview on 5/27/26 at 8:07AM, the state ombudsman reported Resident #8 stated that he (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wasn't getting incontinence care and that he had several urinary tract infections. Per response from staff he is receiving it routinely, he did report he has had several UTIs. Resident #8 also reported the DON (Director of Nursing) said peri care was being done and he was on 15 minute checks and he said this never happened. In an interview on 5/28/26 at 9:15 AM, the Administrator reported the following: She would expect staff to provide oral cares to the residents least every morning and evening. There should not be any reason why this is not being done. It's addressed on the all the Kardex which all the staff have access to. She would expect staff to provide peri care to the residents after every incontinent episode and upon rising and before they go to bed. When asked why Resident #8 did not have any peri care for 5 days, she reported he just had peri care just before he made that statement. A review of the Facility Policy titled: Oral Care with the last revision date of 5/15/20 had documentation of the following: For a patient who can't expectorate or is dependent for oral care If necessary, insert a bite block or mouth prop to hold the patient's mouth open during oral care. Brush the patient's teeth, gums, and tongue with a soft compact-head toothbrush and toothpaste at least twice per day but ideally four times per day. Brush the teeth for at least 2 minutes at each session using the brushing method described above. A review of the Facility Policy titled: Perineal Care dated as last revised February 2018 had documentation of the proper procedure, but failed to direct staff on the frequency that perineal care should be provided.

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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. Based on clinical record review, facility policy review, and staff and resident interviews, the facility failed to separate 2 residents (Resident's #11 and #12) from one another after one of the residents made verbal threats that she would hit the resident, and subsequently observed behind the resident with her arm raised in the air as if to strike the resident. As a result of the failure to separate the residents, Resident #11 was able to strike Resident #12 in the head in the dining room during the breakfast meal, at a time when staff were in the area and could have taken action to prevent it. Resident #12 sustained a bruise on her face and requested transfer to another facility. The facility reported a census of 35 residents. Findings include:The Minimum Data Set (MDS) Assessment tool with reference date 4/16/26 revealed Resident #11 had diagnoses that included hypertension (high blood pressure), diabetes, anxiety, asthma and insomnia, scored 14 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment, that indicated intact cognition, without symptoms of delirium present. The assessment revealed the resident required substantial staff assistance for transfers to and from bed or chair, dressing, toileting, bathing and walking 10 feet or less. The resident used a wheelchair and walker for mobility. The resident was always able to make herself understood and always understood others. The Nursing Care Plan included the following problems:(Resident's name redacted) does not acknowledge or perceive that they exhibit behaviors that may interfere with care, socialization, or safety (e.g., verbal aggression, exit seeking, refusal of care.), initiated 7/15/25, with 8/8/26 goal: Staff will respond to behaviors using nonconfrontational, supportive techniques. The Nursing Care Plan directed staff with interventions that included:A. Avoid using the word behavior when speaking with the resident, initiated 7/15/25, revised 1/8/26. B. Offer preferred activities based on past interests, initiated 7/15/25. C. Provide a structured routine to reduce confusion and agitation, initiated 7/15/25. D. Redirect without confrontation, initiated 7/15/25. 2. (Resident's name redacted) exhibits episodes of physical aggression toward peers related to impaired coping skills, poor impulse control, behavioral dysregulation, cognitive impairment, and/or psychiatric diagnoses, placing self and others at risk for injury, initiated 5/26/26, with 8/8/26 goal: (Resident's name redacted) will be free from any altercations with peers through the next review period. The Nursing Care Plan directed staff with interventions that included: A. Monitor/document behaviors, triggers, antecedents, environmental stressors, peer interactions, and effectiveness of interventions, initiated 5/26/2026. B. Remove resident from overstimulating or triggering environments as needed tomaintain safety, initiated 5/26/2026.C. Staff to approach resident calmly with non-threatening communication and utilize de-escalation/redirection techniques at earliest signs of agitation, initiated 5/26/2026. The facility's undated Abuse Policy directed staff, in part: 1.Abuse is defined as the willful infliction of injury, unreasonable confinement,intimidation, or punishment with resulting physical harm, pain or mental anguish.Abuse also includes the deprivation by an individual, including a caretaker, of goodsor services that are necessary to attain or maintain physical, mental, and psychosocialwell-being. Instances of abuse of all residents, irrespective of any mental or physicalcondition, cause physical harm, pain or mental anguish. It includes verbal abuse,sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabledthrough the use of technology. 2.The resident has the right to be free from abuse, neglect, misappropriation of residentproperty, and exploitation as defined in this subpart. This includes but is not limited tofreedom from corporal punishment, involuntary seclusion and any physical or chemicalrestraint not required to treat the resident's medical symptoms. 3.The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. 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. 4.Prevention- Provide staff, residents, and family members information on how to andwhom to report (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concerns, incidents, and grievances without fear of retribution, andprovide feedback regarding the concerns; identify, intervene, and correct situations ofalleged, suspected, or substantiated abuse; supervision of staff, monitoring ofresident's with needs and behaviors, communication deficits, and/or those totallydependent on staff. 5.The Facility shall have processes in place to include screening, training, prevention,identification, protection, investigation, reporting and response to allegations of potential oractual abuse and neglect. 6.The facility will coordinate investigation outcomes with the Quality Assurance and QualityImprovement committee for purposes of review and to determine the need for further actions. 7.All reports of resident abuse, neglect, exploitation, misappropriation of resident property,mistreatment and/or injuries of unknown source (abuse) or a reasonable suspicion of a crime shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by the administrator and or designee. Those who report allegations of potential or actual abuse and neglect shall be free from retaliation or reprisal. Nursing Progress Notes revealed the following entries: 5/25/26 at 8:28 a.m., transcribed by Staff B, Registered Nurse (RN): Resident#11 noted by staff to have hit a fellow resident in the head with her water jug. Resident#11 removed from the dining room and away from fellow resident. This resident had already called 911 on fellow resident stating she was going to hit her. No reasoning given as to why she was wanting to hit her. 5/25/26 at 11:41 a.m., transcribed by the Director of Nursing (DON): Resident#11observed seated in the dining room during meal service. Resident then quietly propelled herselfacross the dining room toward her roommate (Resident#12) who was seated at another table. Without verbal interaction or identifiable provocation, resident raised her water cup and struck fellow resident in the head. Staff immediately intervened and separated both residents to prevent further escalation. Resident was removed from the dining area for safety and monitored following incident. Resident unable/unwilling to provide explanation for behavior when approached by staff. During an interview on 5/27/26 at 11:50 a.m. the resident stated Resident #12 was her roommate for about 2 weeks and they didn't get along. Resident#12 (R12) would yell, wake her up at all hours of the night, Resident #11 thought R12 was doing it on purpose, would tell her to stop yelling, that she was trying to sleep, but R12 wouldn't stop yelling. Resident #11 stated she thought R12 had some control over what she did and said and was tired of getting woke up by Resident #12. Resident #11 stated she hit R12 with her coffee mug in the Dining Room and held the mug up to indicate what she hit R12 (an approximate16-20 oz sized metal thermal cup with handle, lid and straw in it). Staff interviews revealed: 5/28/26 at 8:42 a.m. Staff K, Certified Nursing Assistant (CNA) stated she worked day shift on 5/25/26, she got Resident #12 up with Staff C, CNA, as her roommate, Resident #11 had been verbal with Resident #12 over waking her up and said she was going to hit her. Nothing happened while they were in the room. As they backed Resident #12 in her wheelchair out of the room Resident #11 was in the hall and had her arm raised up in the air behind her as if she was going to hit R12 and they were able to separate them at the time. She told the nurse on duty, Staff B, because she had never seen Resident #11 become physical before. She asked the nurse if they should move 1 of the resident's from the room they shared to separate them. 5/28/26 at 8:54 a.m. Staff C, CNA stated she worked day shift on 5/25/26, she was with Staff K in the room with Resident's #11 and #12, Resident #11 yelled at Resident #12 about waking her up and said she was going to hit R12. When they took R12 out of the room Resident #11 was behind them in the hall with her arm raised up as if to hit R12 and they were able to keep them separated. Staff K reported it to the nurse, Staff B because they had not seen the resident get physical like that. Staff C was in the Dining Room during breakfast but didn't see Resident #11 strike R12. Resident #11 can self propel in her wheelchair and she got herself over to R12's table, that's where she hit her with her Yeti. 5/28/26 at 7:31 a.m. Staff L, CNA stated she worked day shift on 5/25/26, when Staff K got Resident #12 up, her roommate Resident #11 said she was going to hit her. Staff C helped get the resident up and she heard it too. Staff L stated Staff K told the nurse on duty, Staff B, that Resident #11 said she was going to hit R12, but no changes were made before Resident #11 hit R12 with her coffee mug. 5/28/26 at 12:28 p.m. Staff B, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN, stated she didn't recall that staff informed her that Resident #11 said she would hit R12 on 5/25/26, and she couldn't make any resident room changes, management would have to do that. Once they were up and out of their room R12 sat on the opposite side of the Dining Room from Resident #11, and then R12 stayed out by the TV throughout the day while Resident #11 went back to her room and they would have stayed apart that way. 5/28/26 at 12:17 p.m. Staff M, CNA stated she worked day shift on 5/25/26. She was at the table with R12, the resident fed herself oatmeal after she sat her up, Resident #11 was in her wheelchair, came up to the table and hit R2 in the face with her thermos mug. She didn't say anything before she did it but afterwards she asked if she was bleeding or if she had hurt her. R12 cried and said she didn't feel safe there. Staff said that Resident #11 had been fighting with R12 about waking her up that morning but they didn't say that she said she was going to hit her. 5/27/26 at 5:48 a.m. Staff N, Licensed Practical Nurse (LPN), stated she worked the night shift from 6 p.m. on 5/24/25 to 6 a.m. on 5/25/26, to her recollection she did not recall that R12 was awake, or might have yelled out 1 time. Resident #11 had a history of not getting along with her roommates, she wants to sleep at night and when R#12 has yelled and kept her awake Resident #11 yells back at her to be quiet, that she wanted to sleep and she could hear those exchanges from the Nurse's desk area. She had not heard Resident #11 that night, she can be very verbal but she had never known her to physically threaten anyone, and she was surprised to learn that Resident#11 hit R12 that morning. 5/28/26 at 8:26 a.m. the Director of Nursing (DON), stated If a resident threatened to hit or hurt another resident she expected staff to separate the residents, maintain the residents safety/separation and notify her or the Administrator for further direction. 2. The Minimum Data Set (MDS) Assessment tool with reference date 4/30/26 revealed Resident #12 had diagnoses that included hypertension (high blood pressure), cerebrovascular accident (a stroke), diabetes, seizure disorder, anxiety, depression, acute pain due to trauma, other fractures and sedative, hypnotic or anxiolytic abuse, uncomplicated and cocaine abuse in remission. The assessment revealed the resident was always able to make herself understood and always understood others, scored 11 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment that indicated mild cognitive impairment, without symptoms of delirium present. The resident required maximal staff assistance to reposition in bed, transfer to or from bed or chair, dressing, toileting and hygiene and the resident unable to stand or ambulate. The Nursing Care Plan included a problem labeled as (Resident's name redacted) has a behavior problem, initiated 4/28/26, with 7/29/26 goal: the resident will have no evidence of behavior problems by review date. The Nursing Care Plan directed staff to provide interventions that included:Administer medications as ordered. Observe for/document side effects and effectiveness, initiated 4/28/26.Anticipate and meet the resident's needs, initiated 4/28/26.Explain all procedures to the resident before starting and allow the resident time to adjust to changes.Provide a program of activities that is of interest and accommodates resident's status, initiated 4/28/26. A Nursing Progress Note transcribed by Staff B, RN, on 5/25/26 at 8:28 a.m. stated: resident sustained a hit in the head from a fellow resident. Resident was sitting at the dining room table eating when fellow resident approached her and hit her in the head with her water cup, two residents separated after incident. The next entry in the Nursing Progress Notes by Staff B on 5/25/26 at 8:30 a.m. stated resident voiced she wants to be transferred to another facility due to incident, moving to our sister facility. An Incident Report dated 5/25/26 at 8:28 a.m. described the incident, reported no injuries observed at the time, a pain assessment Painad score of 5 (Pain Assessment in Advanced Dementia) is an observational tool used to evaluate pain in patients with severe cognitive impairments or dementia who cannot verbally communicate their pain. It scores five specific physical behaviors on a scale from 0 to 2, totaling 10 possible points. The Incident Report revealed a bruise on the top of the scalp post-incident reported, without further description or remarks. The facility's 5-day Investigation Summary, completed by the Administrator, stated, in part: Resident's name redacted had a purple bruise next to her right eye 3 centimeters (cm) by 1 cm. Call placed to local law enforcement with case number assigned. Resident's name redacted reports that (continued on next page)

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	165381	A. Building B. Wing	05/28/2026

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she does not want to go to the Emergency Room. Ice pack and first aid were offered to resident, and she declined.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interview, the facility failed to answer call lights timely for two of three residents reviewed (Residents #6 reported he had to wait at least 30 minutes to get his call light answered 3 to 4 times a week and Resident #8 reported to has to wait over an hour to get his call light answered on a daily basis). The facility reported a census of 35 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment tool with reference date 2/19/26 revealed Resident #6 admitted to the facility 11/14/25 with diagnoses that included quadriplegia, seizure disorder, anxiety, depression, asthma, skin graft failure and stage 4 pressure ulcer, scored 15 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment, that indicated intact cognition and without symptoms of delirium present, always able to make himself understood and always able to understand others. The assessment revealed the resident had deficits of bilateral upper and lower extremities, totally dependent on staff assistance for all care that included repositioning in bed, transfers to and from bed or chair, bathing, dressing, eating, toileting and personal hygiene, the resident unable to stand or ambulate. The Nursing Care Plan included a problem labeled (Resident's name redacted) requires total assistance with activities of daily living due to impaired mobility related to quadriplegia. (Resident's name redacted) has a history of expressing inaccurate or inconsistent statements regarding care interactions, creating potential risk for misinterpretation and emotional distress for both the resident and staff. initiated 11/24/25, with 6/5/26 goal: (Resident's name redacted) will remain free from physical injury, psychological harm, and perceived or actual care concerns through consistent use of two-person assistance and clear communication strategies. The Nursing Care Plan directed staff to provided care that included: 1. Explain each step before and during hands-on care. 2. Offer choices when possible. 3. Maintain privacy (doors closed, curtains pulled). 4. Provide cares in pairs for all personal care tasks including: transfers, hygiene and peri-care, dressing, bed mobility, bed bath and repositioning. 5. Validate concerns without arguing or escalating. 6. Reinforce expectations and boundaries respectfully. 7. Avoid defensiveness if reports are made, respond per policy. Resident interviews revealed: During an interview 5/21/26 at 9:48 a.m., Resident #6 stated he was dependent on staff for all care due to quadriplegia, used [NAME] to activate his cell phone to call the facility when he required assistance, it could take 30 or more minutes at least 3 to 4 times a week for staff to respond to his (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	calls for help and it often was at least 15 minutes before staff responded. The resident stated they did not have enough staff at the facility, there was only 1 nurse and 2 aides on the night shift and they were often busy. He usually had to call to ask for assistance to reposition on the night shift, with delayed staff responses he hadn't been repositioned for over 2 hours several times. 2. The Minimum Data Set (MDS) dated [DATE] identified Resident #8 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 and had the following diagnoses: Traumatic Spinal Cord Dysfunction, Quadriplegia, Neurogenic Bladder and Diabetes Mellitus. The MDS also identified Resident #8 to be totally dependent on staff for assistance with all activities of daily living and had an indwelling urinary catheter. On 5/14/26, the Care Plan identified Resident #8 with the problem of falsely accusing the staff of excessive call light wait times and directed staff to respond to call lights promptly and acknowledge resident's concerns respectfully. In an observation and interview on 5/20/26 at 11:30 AM Resident #8 sat up in bed wearing a hospital gown with red stains near neckline. The suprapubic catheter was connected to a drainage bag in a dignity bag below the bladder level. Resident #8 reported the following The longest he had to wait for staff to answer his call light was 4.5 hours. On 4/17/26 at 4:00 AM he turned on his call light, due to pain in his legs from spasms. No one responded until 5:30 AM. They always say they were busy or couldn't hear his call light because they were in another resident's room. c .On 4/24/26 at 1:15 PM he turned on his call light and staff did not come in until 1.5 hours later at 2:45 PM. d .On 5/9/26 at 12:20 PM, he told a CNA that he needed to get cleaned up after a BM and no came to his room until 1:25 PM. e. On 5/9/26 at 5:35 PM, he had another BM, he asked a CNA to clean him up. At 6:50 PM, no one still had come in, so he turned on his call light again. At 7:05 PM, they responded. He stated he did not have a pressure ulcer, but he has to sit 1.5 hours in his stool. f. On 5/9/26 at 7:40 PM, I hit my call light and at 9:06 PM, one CNA came in and said she was going to get help and 2 hours later they finally came in to clean him up. He had to sit in his stool for a total of four hours that one day. g. On 5/9/26 at 7:10 PM, he told the aides that he had not had a bed bath on May 8 or 9 and by 10:30 PM came around, they never got around to giving him a bed bath. That was 2 weeks in a row, they missed giving him his bed bath on Fridays and never made up for it on Saturday like they're supposed to. In an interview on 5/21/26 at 2:53 PM, Resident #8 reported the following: On 5/20/26 at 4:20 PM, he turned on the call light and no one came in until 6:15 PM (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/26 at 6:40 PM, he had another BM, he initiated his call light again. At 7:15 PM a CNA came in and said she was going to get help and left the room. 30 minutes later, no one came to his room and he turned on his call light again and no one came until 7:55 PM. He had to wait 1 hour and 15 minutes before they cleaned him up. c. On 5/21/26 at 11:10 AM he let a CNA know that he needed to be cleaned up. At 11:40 AM the staff cleaned him up. In an interview on 5/22/26 at 8:28 AM, the DON (Director of Nursing) stated there have been problems with staffing, she knows they're going to get tagged on it because there are staff that call in sick daily especially on 2nd and 3rd shift. Management staff have had to work on off shifts to help fill in the gaps. Corporate will not approve her plan to request 3.6 staffing for the acuity of residents that the facility has, they have a lot of psych residents that are demanding. In an interview on 5/26/26 at 12:18 PM, Staff C, CNA reported she did not feel there was enough staff to provide residents with the are they need. On night shift there are typically two nurses and two CNAs. There used to be 3 CNAs, but one aide is on light duty. During the day shift on weekends, there is usually just two CNAs to take are of 30+ residents. They will schedule agency, but most of the time they will call in sick or just a no call, no show. One of the aides has worked 14 days in a row to help out on the weekends. At least half of the residents require two aides for cares. In an interview on 5/26/26 at 1:58 PM, Staff A, CNA reported staff should answer call lights within 15 minutes and that Resident #8 will complain daily that it takes too long for staff to answer his call light. In an interview on 5/26/26 at 3:02 PM, Staff D, CNA reported staff should answer a resident's call light within 15 minutes, but it takes at least 30 to 45 minutes, this is part of the reason she left. Typically on day shift, there is one nurse, one CMA (Certified Medication Aide) and 3 CNAs but there are quite a few call offs. She also said she has worked by myself with over 35 residents before they could find someone to come in. People would call in sick at least once every weekend. A few weekends ago, she worked 6:00 AM to 6:00 PM, they were short, she ended up working until 2:00 AM as no one came in to relieve her at 10:00 PM. She did not feel there was enough staff to give residents the are they need as at least half of the residents require cares in pairs and eleven residents require transfers with a mechanical lift. In an interview on 5/28/26 at 9:15 AM, the Administrator reported she would expect staff to answer call lights within 15 minutes. She reported she looked through all the grievances, resident council meeting minutes and could not find any complaints about call lights. A review of the Facility Policy titled: Answering the Call Light dated as last revised September 2022 had documentation of the following: Answer the resident call system immediately. If the resident needs assistance, indicate the approximate time it will take for you to respond. If the resident's request requires another staff member, notify the individual. If the resident's request is something you can fulfill, complete the task within five minutes if possible. If you are uncertain as to whether or not a request can be fulfilled, or if you cannot fulfill the resident's request, ask the nurse supervisor for assistance.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interview the facility failed to provide occupational therapy for one ofone residents reviewed for occupational therapy services. (Resident#8). The facility reported a resident census of 35. Findings include:The Minimum Data Set (MDS) dated [DATE] identified Resident #8 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 and had the following diagnoses: Traumatic Spinal Cord Dysfunction, Quadriplegia, Neurogenic Bladder and Diabetes Mellitus. The MDS also identified Resident #8 to be totally dependent on staff for assistance with all activities of daily living and had an indwelling urinary catheter. A review of the Physician Orders revealed an order dated 11/6/25 for Occupational Therapy to evaluate and treat as ordered. A review of Occupational Therapy progress notes revealed the last entry was dated 4/2/26. The Care Plan with the last revision date of 3/4/26 identified Resident #8 with the problem of being a quadriplegic, however, failed to address the order for Occupational Therapy dated 11/6/25. On 5/20/26 at 11:30 AM Resident#8 reported that he had not received occupational therapy for activities of daily living. In an interview on 5/26/26/ at 1:03 PM, Staff B, RN reported the following: Resident was getting OT and getting a TENS unit, however the Occupational Therapy Assistant has not worked with him for at least several weeks and could not explain why the OTA has not seen him when he continues to get physical therapy. In an interview on 5/26/26 at 3:43 PM, the Occupational Therapy Assistant reported it has been a month she worked with Resident #8 last on upper body, muscle to get him to do a grasp and maintain tone in his muscles. The visits stopped because the recertification was not done and she cannot provide services until the Occupational Therapist completes the recertification. The Occupational Therapist had a family illness which is why they are behind on the recertifications. Resident #8 is on her schedule definitely for tomorrow. In an interview on 5/28/26 at 9:15 AM, the Administrator reported regarding Resident #8's occupational therapy, the Occupational Therapist does need to write up a recertification. The facility did not have full time in house therapy staff, they are as needed (PRN) for but work for the facility.