| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165381 | A. Building<br>B. Wing | 09/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stone Cottage Care Center | 900 South Stone Street<br>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 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.<br><br>Based on professional certification review and staff interviews, the facility failed to employ a qualified person to serve as the Dietary Manager in the absence of a full-time dietitian. The facility reported a census of 30 residents. Findings include:As of 9/2/25, the facility lacked documentation that Staff E Dietary Manager(DM) completed the Certified Dietary Manager(CDM) course.On 9/3/25 at 11:00 a.m., Staff E stated she did not complete the CDM course. She stated she started in August 2025 and would finish in December 2025. On 9/4/25 at 12:27 p.m., the Administrator stated the DM should be certified. She stated she was enrolled last year but did not finish and was currently in the course again. She stated she did not have a policy regarding DM qualifications. |

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 |
|---|---|---|---|
| | 165381 | A. Building<br>B. Wing | 09/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stone Cottage Care Center | 900 South Stone Street<br>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 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>Based on review of Quality Assurance and Performance Improvement(QAPI) meeting documentation, policy review, and staff interview, the facility failed to maintain documentation that the facility carried out Quality Assurance(QA) activities to develop, implement and evaluate corrective actions or performance improvement activities and take action to conduct structured, systematic investigations, analysis of underlying causes or contributing factors of problems affecting facility-wide processes that impact quality of care, quality of life, and resident safety. The facility reported a census of 30 residents.Findings include:The Centers for Medicare and Medicaid Services(CMS) 2567, dated 9/26/24, listed, in part, the following concerns from a Recertification Survey, and Complaint investigations: F658, F695, F801, F865, F887.The CMS 2567, dated 3/24/25, listed, in part, the following concerns from an investigation of a Facility Reported Incident: F550The current survey, conducted 9/2/25-9/4/25, also identified the above concerns (see F550, F658, F695, F801, F865 and F887). On 9/4/25 at 2:31 PM, the Administrator reported she and the Director of Nursing (DON) immediately pulled the previous 2567s, recognized the concerns in QAPI, investigated to find the root cause and provided staff education. The Administrator reported being in her position for 2 months. On 9/4/25, review of QAPI meeting documentation since the previous survey to present revealed a lack of documentation of QAPI activities in relation to the above identified deficient practices. The facility lacked evidence of an ongoing QAPI program related to the above areas including a process of addressing how the committee would conduct the activities necessary to identify and correct quality deficiencies. The facility lacked documentation of monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revision as needed. Review of the facility policy, titled Quality Assurance and Performance Improvement policy, dated 9/2022, revealed the facility would maintain documentation and evidence of systematic identification, reporting, investigation, analysis and prevention of adverse events. The facility would document the development, implementation and evaluation of corrective action or performance improvement activities through a data-driven QAPI program that focused on the indicators of the quality of life and quality of care. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165381 | A. Building<br>B. Wing | 09/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stone Cottage Care Center | 900 South Stone Street<br>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 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>Based on record review, resident interviews, resident council minutes, staff interviews, and policy review the facility failed to provide sufficient nursing staff to ensure resident needs were met in a timely manner. During the survey 4 of 5 residents reviewed for call lights (Residents #6, #8, #11, #12) reported waiting as long as 90 minutes for call lights to be answered. The facility reported a census of 30 residents. Findings include:1) The Minimum Data Set (MDS) for Resident #6 dated 8/23/25 documented diagnoses of epilepsy, schizophrenia, Post Traumatic Stress Disorder (PTSD), and repeated falls. The resident's Brief Interview for Mental Status (BIMS) score was recorded as 15/15 which indicated intact cognition. Section GG documented the resident needed set up assistance with lower body dressing and substantial to maximal assistance with bathing and tub/shower transfers. The resident was marked as frequently incontinent. On 9/2/25 at 4:01 PM the resident stated sometimes she spent a half an hour or more waiting for help to use the bathroom or get cleaned up. She reported it took a half hour for staff to answer her light so she could use the toilet that morning. When asked how she knew it was a half hour, the resident lifted up her watch and pointed to it. 2) The MDS for Resident #8 dated 7/10/25 listed diagnoses of stroke, paraplegia, epilepsy, and bipolar disorder. The resident's BIMS was documented as 14/15 which indicated intact cognition. Section GG indicated the resident used a wheelchair and needed substantial/maximal assistance with toileting, personal hygiene, bed mobility, and tub/shower transfers. On 9/2/25 at 4:08 PM Resident #8 reported lights could take 30 minutes or longer and stated staff just didn't take the time to make sure the resident had all they needed before they left the room. She stated she was lucky if they got 5 minutes. She also said call lights were often longer than 15 minutes and she could tell by watching the time on her phone. 3) The MDS for Resident #11 dated 8/10/25 listed diagnoses of chronic kidney disease, anxiety disorder and depression, and unsteadiness on their feet. The resident's BIMS was documented as 13/15 which indicated intact cognition. Section GG indicated the resident used a wheelchair and was dependent on staff assistance for toileting, personal and oral hygiene, dressing, bed mobility, and transfers. On 09/02/2025 at 11:08 AM Resident #11 stated she was not happy with the care. She indicated her call light that morning was long, well over 15 minutes, and the night shift light times were the worst. She reported call light wait times as long as 1.5 hours. The resident knew they were that long because she had a clock on her wall and watched the time. She pointed out the commode in her room and said even with that staff took so much time she didn't always make it. She stated staff were kind, there were just not enough of them to help everyone when they needed it. The resident gave the example she thought staff were supposed to come see if she had to go to the bathroom every 2 hours or so but they did not do that. 4) The MDS for Resident #12 dated 8/28/25 listed diagnoses of heart failure, UTI (Urinary Tract Infection) in the past 30 days, and schizoaffective disorder. The resident's BIMS was documented as 15/15 which indicated intact cognition. Section GG indicated the resident used a wheelchair and needed substantial/maximal assistance with transfers to her chair, bed, and toilet. On 09/02/2025 at 12:31 PM the resident stated she had a call bell not a call light and that other people had them too. She stated they all made the same sound with no distinction, so staff don't know where to go. She reported she has had to wait a half hour or more to get help. She used her cell phone to monitor the time. That morning she pulled the cord in her bathroom and waited almost exactly 20 minutes. The resident also reported times she was in the hallway, saw call lights go on for other residents, and saw staff remain seated at the nurses station not answering them right away even though they could see the light indicator.A document titled Resident Council Meeting Summary dated May 2025 documented residents identified for nursing that participants needed the weekend aides to be quicker answering call lights. The document did not include follow up with the residents.During an interview on 9/3/25 at 5:00 PM Staff A, Certified Medication Aide (CMA) reported staff were trained to answer call lights within 15 minutes. She (continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165381 | A. Building<br>B. Wing | 09/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stone Cottage Care Center | 900 South Stone Street<br>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 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | indicated there were more residents in the facility with behavioral needs now and sometimes there were sacrifices on their end to address all of the needs. She stated that answering lights took longer as those needs increased, especially second shift. She confirmed residents had complained about the call lights, some about how long it took to answer them and some about not being able to spend enough time with them.On 9/4/25 at 9:05 AM Staff B, Licensed Practical Nurse (LPN) confirmed staff were trained to answer call lights within 15 minutes. She stated anyone could answer a call light and if they were on for more than 15 minutes it was probably because the resident wanted it kept on until the cares were done. She was not aware of the facility doing call light audits.During an interview on 9/4/25 at 10:04 AM the Director of Nursing (DON) stated they tried to get to call lights faster than 15 minutes. She stated resident complaints about call lights should include completing a grievance with follow up education for the staff. The DON reported it was hard to have a toileting program due to resident behaviors. She confirmed there had not been call light audits since she had been there.A policy titled Call Lights: Accessibility and Timely Response dated 12/1/23 documented all staff members who saw or heard a call light or the call system were responsible for responding. If the staff member could not provide what the resident needed, they should notify appropriate personnel. Staff were directed to first turn off the call light, then listen to the resident's request and respond accordingly. If further assistance was needed, the staff responding to the light were to inform the appropriate personnel or summon additional help using the call light and stay with the resident until help arrived. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165381 | A. Building<br>B. Wing | 09/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stone Cottage Care Center | 900 South Stone Street<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on observation, clinical record review, policy review, and staff interviews, the facility failed to interact with a resident in a respectful manner for 1 of 3 residents reviewed for dignity(Resident #26). The facility reported a census of 30 residents.Findings:The Quarterly Minimum Data Set(MDS) assessment tool, dated 7/17/25, listed diagnoses for Resident #26 which included heart failure, diabetes, and hemiplegia(one-sided paralysis) and listed her Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. Care Plan entries, dated 8/19/25, stated the resident had chronic obstructive pulmonary disease and directed staff to administer aerosol or bronchodilators(medications that treated breathing conditions) as ordered. On 9/4/25 at approximately 8:45 a.m., Staff A Certified Medication Assistant(CMA) provided the resident her Symbicort inhaler(a medication inhaled which helped with breathing conditions) and the resident inhaled 2 puffs. After this, Staff A provided the resident a glass of water and the resident swished her mouth and swallowed the water. The resident then said she had to spit and spit into a tissue. Staff A then turned to the State Agency(SA) with a disgusted look on her face as she gestured with her head toward the resident and said ew loogie. The staff member and the resident were near the dining room where other residents and staff were present. The facility policy Resident Rights, revised June 2023, stated employees shall treat residents with kindness, respect, and dignity. On 9/4/25 at 11:02 a.m., when queried regarding Staff A's comment and behavior toward the resident, the Director of Nursing(DON) stated it was not appropriate. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165381 | A. Building<br>B. Wing | 09/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stone Cottage Care Center | 900 South Stone Street<br>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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on observation, clinical record review, policy review, and staff interivew, the facility failed to ensure a resident rinsed their mouth in accordance with professional standards for 1 of 1 residents reviewed for the administration of an inhaler(Resident #26). The faciltiy reported a census of 30 residents. Findings:The Quarterly Minimum Data Set(MDS) assessment tool, dated 7/17/25, listed diagnoses for Resident #26 which included heart failure, diabetes, and hemiplegia(one-sided paralysis)and listed her Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. The facility policy Provision of Physician Ordered Services, dated 12/23, stated the purpose of the policy was to provide physician ordered services according to professional standards of quality. The September 2025 Medication Administration Record(MAR) listed a 3/24/22 order for Symbicort Aerosol 160-4.5 micrograms[mcg] (budesonide-formoterol fumarate, an inhaler which treats lung conditions) 2 puffs twice daily. The MAR directed staff to ensure the resident rinsed their mouth with water after the inhalation and not to swallow.The Symbicort Highlight of Prescribing Information, retrieved from https://drd9vrdh9yh09.cloudfront.net/50fd68b9-106b-4550-b5d0-12b045f8b184/a4b62ab8-1314-4583-91b4-29 on 9/4/25 at 1:50 p.m. stated the medication could cause infections of the mouth and throat and directed staff to advise the resident to rinse their mouth with water without swallowing after inhalation to help reduce the risk. On 9/4/25 at approximately 8:45 a.m., Staff A Certified Medication Assistant(CMA) provided the resident her Symbicort inhaler(a medication inhaled which helped with breathing conditions) and the resident inhaled 2 puffs. After this, Staff A provided the resident a glass of water and the resident swished her mouth and swallowed the water. Staff A did not provide her a cup to spit into or encourage her to spit out the water she swished with. On 9/4/25 at 11:02 a.m., the Director of Nursing(DON) stated staff should have residents swish and spit after utilizing a Symbicort inhaler. She stated with Resident #26 they should remind her to spit out the water. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165381 | A. Building<br>B. Wing | 09/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stone Cottage Care Center | 900 South Stone Street<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on observation, clinical record review, policy review, and staff interview, the facility failed to notify the physician of a resident's refusal of an ordered diet and failed to carry out specialized Speech Therapy(ST) services for a diagnoses of dysphagia(difficulty swallowing) for 1 of 2 residents reviewed for a change in condition(Resident #10). The facility reported a census of 30 residents. Findings include:The Quarterly Minimum Data Set(MDS) assessment tool, dated 8/16/25, listed diagnoses for Resident #10 which included dysphagia(difficulty swallowing), Parkinson's disease(a disease which caused tremors and lack of mobility), and anxiety disorder. The MDS stated the resident had a mechanically altered diet and listed his Brief Interview for Mental Status(BIMS) score as 14 out of 15, indicating intact cognition. The facility policy Provision of Physician Ordered Services dated 12/23, stated the facility would provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality. A 7/16/25 5:40 p.m. Nursing Note stated the resident reported that he ate roast beef for lunch and it felt like it was caught in his esophagus. A 7/17/25 2:52 p.m. Nursing Note stated the resident requested a scope due to the roast beef which was stuck and stated he had this happen his whole life. The resident's provider ordered a transfer to the ER for evaluationA 7/17/25 6:26 p.m. Nursing Note stated the resident would transfer to another hospital for a scope. A 7/19/25 5:02 a.m. Nursing Note stated the resident had an endoscopy(a scope inserted through the mouth to visualize the upper digestive system) completed and was on a liquid diet for two weeks and then would advance to a pureed diet. A 7/24/25 Care Plan entry stated the resident had a swallowing problem.An 8/5/25 Care Plan entry stated the resident refused his pureed diet and wanted a mechanical soft diet. An 8/5/25 Fax cover Sheet from the facility to the provider stated the resident completed 2 weeks of a full liquid diet and started a pureed diet today. The form inquired how long the resident was to have a pureed diet before advancing to a regular diet. The provider then inquired if they had Speech Therapy (ST) and directed ST to advance the diet if able. A note on the fax stated the resident had an order for ST. On 9/3/25 at 11:25 p.m., during the noon meal service, Staff D [NAME] prepared a mechanical soft meal consisting of ground chicken alfredo for Resident #10. The Dietary Manager stated the resident refused his ordered pureed diet so they provided him with mechanical soft foods. The facility lacked documentation of the initiation of Speech Therapy (ST) services and lacked communication to the provider that the resident refused his ordered pureed diet. On 9/4/25 at 11:02 a.m., the Director of Nursing(DON) stated the provider wanted the facility to follow up with ST for the resident. She stated she was not sure how often ST came into the building. On 9/4/25 at 1:36 p.m., Staff C Occupational Therapy Assistant(OTA) stated she received an order for ST at the end of July or the beginning of August and had not been able to get a therapist to visit. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165381 | A. Building<br>B. Wing | 09/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stone Cottage Care Center | 900 South Stone Street<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interviews, staff interviews, and the facility policy, the facility failed to adequately supervise a resident after they went outside without oxygen for 1 of 1 residents reviewed for elopement (Resident #22). The facility reported a census of 30 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 scored a 8 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition moderately impaired. The MDS revealed medical diagnosis of Chronic Obstructive Pulmonary Disease (COPD). The MDS indicated the resident utilized oxygen therapy. The Care plan revealed a focus area revised on 11/13/24 for a diagnosis of COPD and is at risk for shortness of breath, impaired breathing and respiratory infections and utilizes O2. The interventions dated 7/9/24 indicated to administer supplemental oxygen (02) as ordered per physician. The Care Plan revealed a focus area revised on 11/13/24 for impaired cognitive function and/or impaired thorough processes as evidenced by short/long term memory deficit, impaired decisions making and/or impaired ability to understand others related to a diagnosis of dementia. The interventions dated 7/8/24 indicated cueing, orienting and supervise as needed. The BIMS exam conducted on 3/24/25 resulted in a score of 2 out of 15, which indicated cognition severely impaired. The EMR revealed the following Physician Orders: a. ordered 4/8/25- Oxygen via n/c 1-5L PRN to keep oxygen greater than 89%.The BIMS exam performed on 4/10/25 resulted in a score of 3 out of 15, which indicated cognition severely impaired. The Weather on 7/24/25 around the facility was the following:a. 1:52 PM: 82 degrees Fahrenheit (F) with 76% humidityb. 2:23 PM: 81 degrees F with 77% humidityc. 2:52 PM: 82 degrees F with 76% humidity The Behavior Note dated 7/24/25 at 3:12 PM, revealed this nurse was summoned by aide of resident was wanting to go outside to the back patio and was refusing to stay indoors due to heat and humidity. Aide assisted resident out to the back door and resident utilized her four wheeled walker and went ot sit on the bench near the patio door. Resident was persistent on going outside and refusing to come in. She stated I just want some fresh air. Educated resident that due to her COPD that she will need her oxygen as she has been having increase difficulty breathing and the humidity will make her breathing worse. Resident stated she did not care and she was fine. Notified aide to monitor resident and will try again later. Nurse she also attempted to talk to resident and she refused to come in. Resident was offered water frequently and oxygen but refused. Notified her to monitor resident for behaviors and place resident on Hot chart. The Nursing Note dated 7/24/25 at 4:20 PM, revealed this nurse notified at this time by another resident and CNA's (Certified Nurse Aide) that resident was no longer sitting outside where she had been. CNA's went out and saw resident walking behind the facility on the side walk with her walker. CNA's tried to get resident to turn around and come back in but resident refused and just kept walking being aggressive towards CNA with her walker if they got in her way. CNA's walked with resident back by the kitchen entrance and resident sat on a bench there. This nurse brought out resident's O2 (oxygen) tank and offered her water. After a little bit of time this nurse and staff were able to get resident to walk inside. DON (Director of Nursing) and Administrator notified of above. Residents daughter returned call to facility and this nurse also notified daughter of the above information with reassurance that resident is without injury and vitals are stable and she will continue to be monitored closely and observed for any changes or concerns. The Incident Note dated 7/24/25 at 5:52 PM, revealed received a call from [name redacted] ADON (Assistant Director of Nursing) at 4:15 PM regarding resident had left the facility grounds by another resident and staff went to go encourage her to return to the facility. [Name redacted] reported resident was refusing to come back into facility at this time. Notified [name redacted] will return to facility. Resident was then able to be redirected back to facility. Nurse obtained oxygen for resident and resident was assisted by aides back inside and into dining room<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165381 | A. Building<br>B. Wing | 09/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stone Cottage Care Center | 900 South Stone Street<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | chair. This nurse arrived shortly after. Vitals obtained and resident assessed. Resident had an elevated b/p (blood pressure) of resident reports to have bilateral edema in feet. This nurse assessed feet and noticed to have non-pitting edema. Resident denied having any pain or discomfort. Spoke with on call physician [name redacted] ARNP (Advanced Registered Nurse Practitioner) and notified of incident and obtained a verbal order for UA (urinalysis) with C & S (Culture and sensitivity). L M (left message) with daughter [name redacted] to return call. Notified [name redacted] with [name redacted] hospice of incident. Notified aides to start resident on 15 minute checks until further reassessment. EMar-Medication Administration Note dated 7/24/25 at 7:12 PM documented the following; Ipratropium-Albuterol inhalation Solution 0.5-2.5 (3)milligrams/3milliliters 1 vail inhale orally two times a day for wheezy/shortness of breath administered.The BIMS exam conducted on 7/24/25 at 8:44 PM by the DON and resulted in a 13 out of 15, which indicated cognition intact.The Behavior Note dated 7/25/25 at 4:24 AM, revealed resident eloped from the facility prior to supper. She has not attempted to leave the facility since this nurse came on to shift at 1800. She received her scheduled Morphine and has been resting quietly in bed all shift. BP (blood pressure) 149/69 T (temperature) 97.2 P (pulse) 75 R (respirations) 18 O2 (oxygen) 96% 4L/NC (liters/nasal cannula). Resident continues on 15 minute checks. During an interview on 9/3/25 at 4:40 PM, Staff K, Business Office Manager (BOM) stated Resident #1 told staff one of the residents was on the loose. Staff K stated no one was with Resident #22 went she started walking towards the back of the building and Resident #22 didn't have her oxygen on. Staff K stated it took 5 staff to get Resident #22 back into the building. During an interview on 9/3/25 at 5:16 PM, Staff A, Certified Nurse Aide (CNA) stated Resident #22 pushed her way outside and it was really hot that day. Staff A stated she hollered for the DON and the DON said Resident #22 could sit out there. Staff A stated she had to get residents up for dinner so every time Staff A got someone up, Staff A would go and check on Resident #22. Staff A stated Staff L, CNA came in around 3:30 PM and Resident #1 told Staff L that Resident #22 left. Staff A stated Resident #22 used her walker to walk around the building and Staff A and other staff went outside to get Resident #22. Staff A stated Resident #22 was outside between an hour and an hour and half by herself. During an interview on 9/4/25 at 8:55 AM, Staff B, Licensed Practical Nurse (LPN) queried if Resident #22 cognitive and Staff B stated not all the time. Staff B stated Resident #22 doesn't always wear her oxygen and when Resident #22 didn't wear her oxygen her pulse oximetry dropped. Staff B stated Resident #22 should wear oxygen if she was outside. Staff B stated she was not aware Resident #22 was outside that day and when Staff B found out, Staff B took Resident #22 oxygen concentrator outside and checked her pulse oximetry and she thought it read in the 70s or 80s, but couldn't remember exactly. Staff B stated Resident #22 coherent when Resident #22 oxygen was low. Staff B stated Resident #22 should have staff with her when outside. During an interview on 9/4/25 at 9:18 AM, Staff L, CNA stated Resident #22 might not be able to sit outside without supervision. Staff L stated her and Staff A went outside to help Resident #22 come in. Staff L stated some days Resident #22 knows everything and other days, Resident #22 was confused. Staff L stated Resident #22 could be outside if someone watched her through the window or sat outside with Resident 22. Staff L stated Resident #22 needed her oxygen all the time and Resident #22 needed oxygen when she was outside. During an interview on 9/4/25 at 10:03 AM, the DON stated Resident #22 cognitively intact and independent. The DON stated Resident #22 not always cognitive, but at the time of the incident, Resident #22 was based on her BIMS score. The DON stated She was not concerned with Resident #22 being outside by herself except for her walking safety. The DON stated Resident #22 wanted to go outside on the hot day and refused her oxygen. The DON stated she was not at the facility the whole time while Resident #22 was outside, but she came back to the facility and did assessments on her after Resident #22 came back in. During an interview on 9/4/25 at 11:13 AM, Resident #1 stated he saw Resident #22 start walking around the building and Resident #1 alerted staff. During an interview on 9/4/25 at 1:03 PM, Staff M, CNA stated when Resident #22 didn't wear her oxygen, Resident #22 got more confused. Staff M stated Resident #22 should not be outside<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165381 | A. Building<br>B. Wing | 09/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stone Cottage Care Center | 900 South Stone Street<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | without her oxygen because she got more confused and short of breath when she walked down the hallway without oxygen. During an interview on 9/4/25 at 1:09 PM, Staff N, CNA queried if Resident #22 cognitive and Staff N stated it varied. Staff N asked if Resident #22 could be outside unsupervised and Staff N stated no because she needed oxygen and to make sure Resident #22 didn't go anywhere. Staff N stated Resident #22 was confused that day she went outside and earlier in the day Resident #22 kept trying to go outside, but they didn't let Resident #22 got unsupervised. Staff N stated Resident #22 was confused that day and not herself. During an interview on 9/4/25 at 1:25 PM, Staff J, CNA queried on if Resident #22 could be unsupervised and Staff J stated she didn't think Resident #22 could. Staff J stated she didn't think it would be a good idea for Resident #22 to go outside by herself for a couple of months now. Staff J stated she would of asked the nurse about Resident #22 not having oxygen while outside and then she would of stayed with her or checked on her. Staff J stated she would of kept eyes or had someone else keep eyes on Resident #22 while she was outside without oxygen. During an interview on 9/4/25 at 1:29 PM, Staff A, CMA stated she believed Resident #22 would be alright unsupervised except for not having her oxygen and with the weather being so hot that day. During an interview on 9/4/25 at 2:15 PM, the DON stated she performed a BIMS after Resident #22 went outside because she always did thorough assessment on residents with any changes. The Facility Oxygen Administration Policy (no date identified) revealed: a. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration.b. Review the resident's care plan to assess for any special needs of the resident.c. Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter. The Facility Accidents and Incidents- Investigating and Reporting dated July 2017 revealed: a. All accidents or incidents involving residents, employees, visitors, vendors, etc. occurring on our premises shall be investigated and reported to the administrator. b. The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165381 | A. Building<br>B. Wing | 09/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stone Cottage Care Center | 900 South Stone Street<br>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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and the facility policy, the facility failed to verify oxygen orders with the hospice provider for 1 of 1 residents reviewed oxygen therapy orders (Resident #22). The facility reported a census of 30 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 scored a 8 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition moderately impaired. The MDS revealed medical diagnosis of Chronic Obstructive Pulmonary Disease (COPD). The MDS indicated resident utilized oxygen therapy. The Care plan revealed a focus area revised on 11/13/24 for a diagnosis of COPD and is at risk for shortness of breath, impaired breathing and respiratory infections and utilizes O2. The interventions dated 7/9/24 indicated to administer supplemental oxygen (02) as ordered per physician. The EMR revealed the following Physician Orders: a. ordered 4/8/25- Oxygen via nasal canula (n/c) 1-5L as needed (PRN) to keep oxygen greater than 89%. b. ordered 8/18/25- Oxygen via n/c 3L PRN to keep oxygen greater than 90%. The Hospice Team Plan revealed the following order start date of 6/9/25a. Oxygen 2-4 Liter continuous Not otherwise specified (NOS) dyspneaDuring an interview on 9/4/25 at 2:17 PM, the Director of Nursing (DON) queried on the oxygen orders from hospice dated 6/9/25 and the DON stated she hadn't looked at them. The DON asked how they collaborated care with hospice and the DON stated hospice usually sent them to the provider and then the orders were sent to the facility. The DON stated she requested for a specific order for one setting for the oxygen instead of the variation of oxygen liters. The DON stated it was her fault because she kept the PRN (as needed) on the order. The Facility Oxygen Administration Policy (no date identified) revealed: Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administrationReview the resident's care plan to assess for any special needs of the resident. The Facility Hospice Services Policy (no date identified) revealed: A provision that when facility staff are responsible for the administration of prescribed therapies, including those determined appropriate by hospice and defined in the hospice plan of care, our facility staff may administer immediately when the facility becomes aware of the alleged violation. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165381 | A. Building<br>B. Wing | 09/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stone Cottage Care Center | 900 South Stone Street<br>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 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observation, clinical record review, policy review, and staff interview, the facility failed to ensure the medication error rate did not exceed 5%. The facility's medication error rate calculated as 7%. The facility reported a census of 30 residents.Findings include:The Annual Minimum Data Set(MDS) assessment tool, dated 7/10/25, listed diagnoses for Resident #8 which included anxiety, hemiplegia(paralysis affecting one side of the body), and paraplegia(paralysis affecting the lower body) and listed her Brief Interview for Mental Status(BIMS) score as 14 out of 15, indicating intact cognition. A Care Plan entry, revised 2/1/24, stated the resident was a smoker.The September 2025 Medication Administration Record(MAR) listed the following orders:a . 7/21/25 Famotidine(a medication used to reduce stomach acid) tablet 20 milligrams(mg) two times per day.b. 7/16/25 nicotine patch(assisted in nicotine cessation) 24 hour 14 mg/hour 1 patch one time a day. On 9/3/25 at 8:16 a.m., Staff A Certified Medication Assistant(CMA) administered Resident #8's morning medications. Staff A stated that she did not have the resident's nicotine patch. Staff A also failed to administer the resident's Famotidine. A 9/3/25 eMar Medication Administration Note stated the facility waited for the resident's nicotine patch to come in.The facility's medication administration error rate calculated as 7%On 9/4/25 at 11:02 a.m., the Director of Nursing(DON) stated staff should have called the pharmacy if a medication was not available. She stated with regard to the omission of the medication, staff should check the medications better. The undated facility policy Medication Administration, stated staff would administer medications in accordance with professional standards of practice and directed staff to follow the manufacturer's product information for inhalers. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165381 | A. Building<br>B. Wing | 09/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stone Cottage Care Center | 900 South Stone Street<br>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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and the facility policy, the facility failed to administer a resident their prescribed controlled medication for 1 of 6 residents reviewed for medication administration (Resident #17). The facility reported a census of 30 residents. Findings include: The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 scored a 10 out of 15 on the Brief Interview for Mental Status, which indicated cognition moderately impaired. The MDS revealed diagnoses for anxiety disorder, bipolar disorder, and seizure disorder or epilepsy. The MDS indicated the resident prescribed antipsychotics, antianxiety, and antidepressant medications. The Care Plan revealed a focus area revised on 9/3/25 for use of antianxiety medications related to a seizure disorder. The interventions dated 9/3/25 directed staff to give the resident anti-anxiety medications as ordered by the physician.The EMR (Electronic Medical Record) revealed the following Physician Orders: a. Ativan Oral Tablet 0.5 MG (Lorazepam) Controlled DrugGive 0.5 mg by mouth two times a day for seizure activity- ordered on 8/11/25The EMR Physician Orders lacked documentation of an order for Oxycodone (opioid analgesic/narcotic) for Resident #17.The Nurse Note dated 8/14/25 at 7:50 AM, documented the resident was given a oxymoron (Oxycodone) instead of her Vatican (Ativan) at hs (bedtime). Dr. and [NAME] (Director of Nursing) notified. Resident monitored and had no adverse reaction. The Incident Note dated 8/19/25 at 1:49 AM, revealed the resident was given and Oxy instead of and Ativan. Dr. and DON notified. No adverse reactions observed. During an interview on 9/4/25 at 11:46 AM, Staff I, Licensed Practical Nurse (LPN) queried on giving Resident #17 an Oxycodone instead of Ativan and Staff I stated she didn't remember making the medication error and it got kind of crazy at night. Staff I asked how the narcotics were stored, Staff I stated all the residents had individual cards with their names on the cards and the narcotics were locked in the narcotic box in the medication cart. During an interview on 9/4/25 at 2:03 PM, the Director of Nursing (DON) queried on the medication error with Resident #17 and the DON stated Resident #17 was given another resident's Oxycodone instead of Resident #17 Ativan. The DON stated she just did a huge skilled assessment with staff on the 5 rights of medication administration. The DON queried on what the 5 rights were and she stated right dose, right resident, right medication, right route, and right time. The Facility Medication Administration (no date indicated) revealed: Identify resident by photo in the Medication Administration Record (MAR)Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication, name, form, dose, route, and time. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165381 | A. Building<br>B. Wing | 09/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stone Cottage Care Center | 900 South Stone Street<br>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 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on clinical record review, policy review, and staff interview, the facility failed to offer a Covid-19 booster to 1 of 5 residents reviewed for immunizations(Resident #3) and failed to provide information to staff regarding the Covid-19 vaccination. Findings included:1. The Annual Minimum Data Set(MDS) assessment tool, dated 6/19/25, listed diagnoses for Resident #3 which included hemiplegia(one-sided weakness), mild intellectual disabilities, and muscle weakness and listed her Brief Interview for Mental Status(BIMS) score as 14 out of 15, indicating intact cognition. The resident's Iowa Health and Human Services vaccination list, stated the resident received a Covid-19 vaccination on 6/27/24. The facility lacked further documentation of education provided to the resident regarding an updated Covid-19 booster. 2. On 9/4/25 at approximately 11:00 a.m., Staff F Laundry Staff stated the facility did not provide information to her regarding Covid-19 vaccinations. On 9/4/25 approximately 1:00 p.m. Staff G Housekeeping staff stated the facility did not provide information to her regarding Covid-19 vaccinations. On 9/4/25 at 11:02 a.m., the Director of Nursing(DON) stated the facility utilized Centers for Disease Control and Prevention(CDC) guidelines for resident vaccinations and should offer residents a Covid booster. On 9/4/25 at 1:27 p.m., Staff H Human Resources(HR) stated she assisted with staff flu vaccinations but stated the facility did not offer or provide education to staff regarding the Covid-19 vaccination. The facility Coronavirus Disease(Covid-19)-Infection Prevention and Control Measures, revised 2023, stated the facility would encourage staff and residents to remain up-to-date with all Covid-19 vaccine doses and to provide resources and counseling about the importance of receiving the Covid-19 vaccine. |