

**Department of Inspections, Appeals, and Licensing
Health & Safety Division
Citation**

Citation Number 10960					Report date November 20, 2025
Facility name Stone Cottage Care Center		Survey dates November 4, 2025 - November 6, 2025			
Facility address 908 S. Stone St. Sigourney, IA 52591					
City Click or tap here to enter text.		CP			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date	
58.28(3)e	481—58.28(135C) Safety. The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III) 58.28(3) Resident safety. e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III) DESCRIPTION Based on observation, clinical record review, and staff and resident responsible party interviews, the facility failed to provide adequate supervision and staff assistance to residents to prevent injuries from falls, for 1 of 4 residents with fall histories reviewed (Resident #4). The facility's failure to provide the appropriate supervision and assistance resulted in Resident #4's hospitalization in a hospital Intensive Care Unit with injuries that included hemothorax, fractured 6th through 10th right ribs, displaced right shoulder and compression fracture of the 10th thoracic vertebrae that resulted from an unwitnessed fall. The facility reported a census of 34 residents. Findings include: The 9/13/25 modified Minimum Data Set (MDS) Assessment revealed Resident #4 had diagnoses	Class I	\$7,750.00	Upon Receipt	

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	that included repeated falls, Wernicke's encephalopathy (a severe neuropsychiatric disorder caused by thiamine deficiency), alcohol dependence with withdrawal delirium, arthritis, irritability and anger, scored 8 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment that indicated severe cognitive impairment, with symptoms of delirium present. The Assessment revealed the resident required moderate staff assistance for toilet transfers, personal hygiene and to don or doff shoes, able to ambulate independently with walker or cane used, and had 1 fall with major injury since the previous assessment completed on 8/16/25. Resident #4's Fall Risk Assessments revealed the following scores; a score of 10 or greater indicated the resident at high risk for falls: 1. 6/10/25 score 10.0 2. 6/25/25 score 11.0 3. 7/8/25 score 11.0 4. 8/16/25 score 11.0 5. 8/30/25 score 17.0 6. 9/13/25 score 17.0			

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	7. 10/1/25 score 15.0 8. 10/9/25 score 13.0 9. 10/14/25 score 14.0 10. 10/16/25 score 13.0 The required quarterly care conferences documented in the resident's record revealed they were completed on 10/3/24, 2/20/25, 5/23/25, 8/26/25 and 9/23/25, and did not include his family or legal representative/power of attorney (POA) as required. The resident's Nursing Care Plan included the following problems and associated interventions: 1. Risk for injury related to poor safety awareness as evidence by disregard for physical limitations or unsafe behaviors, initiated 7/29/2025. Goal with target date 12/22/25: Resident will remain free from injury, revised 9/25/2025. Interventions included: 1. Staff will implement consistent safety interventions to reduce risk, initiated 7/29/2025, revised 9/25/2025.			

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	2. Document all safety behaviors and interventions, initiated 7/29/2025. 3. Educate patient about safety risks and calling for help, initiated 7/29/2025. 4. Initiate regular safety rounding, initiated 7/29/2025. 5. Keep call light and frequently used items within reach, initiated 7/29/2025. 6. Perform cognitive assessment frequently, initiated 7/29/2025. 2. Resident is at risk for falls related to psychoactive drug use, initiated 7/9/24, revised 1/22/2025. Goal with target date 9/22/25: Resident will be free of falls through the review date. Interventions included: 1. Encourage resident to allow staff to pick items up off of the floor for him. He often prefers to do things himself despite the safety risks, initiated 12/30/2024. 2. Be sure resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident			

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	needs prompt response to all requests for assistance, initiated: 7/9/2024. 3. Ensure a safe environment that is free of clutter and has adequate lighting. Clean up spills promptly, initiated 7/9/2024. 4. Resident prefers to wear gripper socks in facility, and not shoes, initiated 9/9/2024. 5. PT/OT (Physical Therapy/Occupational Therapy) to eval and treat, initiated 1/24/2025. 6. OT eval and treat related to fall 6/2/25 to aid in strengthening, initiated 6/2/2025. 7. Sign placed in room to encourage resident to call for help making his bed, initiated 4/12/2025. 8. Tape added to feet of dining room chair to help grip the floor; Yellow tape to mark his dining room chair, initiated 1/24/2025.					

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	3. Resident has potential to demonstrate behaviors and/or experience a fall after events such as: Dr. appointments, facility gatherings, family visits, initiated 8/11/2025. Goal with target date 9/22/25: Resident will demonstrate effective coping skills through the review date, and goal with target date 9/22/25: Resident will not harm self or others through the review date. Interventions included: 1. When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later, initiated 8/11/2025. 4. The resident had an actual fall 6/10/25, 6/25/25, 6/30/25, 7/3/25, 7/8/25, 7/28/25, 8/16/25, 8/18/25, 8/21/25, 8/30/25, 9/1/25, 9/2/25, 9/30/25, 10/22/25, initiated 7/2/25, last revised 11/4/25. Goal with target date 9/22/25: Resident will have no injuries from falls through next review. Interventions included: 1. Encourage resident to keep his door open when in his room, initiated 10/1/2025.				

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	2. Encourage resident to use safe transferring techniques when getting out of dining room chair, initiated 7/2/2025. 3. Resident uses the same dining room chair, indicated by name tag on the back of the chair, initiated 7/2/2025. 4. Medication Evaluation due to recent fall. Resident has had increased behaviors due to Hospital removing routine medication, initiated 8/30/2025. 5. Night light in resident's room, initiated 7/24/2025. 6. Observe for/document/report to MD signs or symptoms of pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation, initiated 7/8/2025. 7. Obtain vital signs per policy/as ordered, initiated 7/2/2025. 8. Orthostatic B/Ps obtained due to recent fall and loss of balance, initiated 7/29/2025.			

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	9. Pharmacy to review medications to help identify root cause of fall, initiated 7/2/2025. 10. Prefers independence with bathing, dressing, hygiene, grooming, toileting, ADLs (Activities of Daily Living) and mobility as the resident is noncompliant with assistance with ADLs, initiated 10/1/2025, revised on 11/4/25. 11. PT consult for strength and mobility, initiated 7/2/2025. 12. Redirect resident from unsafe ambulation when distressed, initiated 8/21/2025. 13. Requests staff offer assistance only when asked or during scheduled checks, initiated 10/1/2025. 14. Resident experiencing increased fall risk potentially related to emotional distress and decreased focus following recent family trauma. 1-on-1s with social services provided, initiated 9/2/2025. 15. Resident is at risk for falls and is non-compliant with established fall interventions (assist with transfers, call light			

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	use, walker use, etc.). Prefers to be independent and often attempts unsafe mobility, initiated 9/30/2025. 16. Resident refused to keep cue signage posted in room, removing or taking down signs. Resident educated on purpose of cue sign and potential fall risk. Resident verbalized preference for no signage and wishes to maintain privacy/independence, initiated 6/30/2025. 17. Resident to utilize wheelchair independently until after strengthening from upcoming surgery to the left ankle, initiated 10/22/2025, revised 11/4/2025. 18. Staff removed empty muscle-rub tubes being used as a door stopper to eliminate environmental clutter and prevent tripping hazards. Resident educated on fall risk associated with storing items on the floor or near door. Resident verbalized understanding. Staff will monitor environment and remove unsafe items as noted. Purposeful rounding initiated to ensure needs met and reduce urgency to move around unsafely, initiated 6/25/2025.			

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	The resident's clinical record revealed he had 20 falls between 6/10/25 and 10/24/25. Ten (10) of the 20 falls occurred in the resident's room and were unwitnessed, 3 of the 10 falls required hospitalization related to the extent of injuries that resulted from the falls on 9/2/25, 9/13/25 and 10/24/25. On 9/2/25 at 2:38 p.m., the resident was found on the floor on his back in his room, blood to shirt and hair noted. Resident stated he tried to stand to put shorts on, lost balance and fell. Laceration on top of left scalp measured approximately 3.5 centimeters (cm) by 0.5 cm. The resident sent to the hospital and then transferred to a tertiary hospital for treatment of subdural hematoma (bleeding on the brain) and closed fracture of vault of skull (skull fracture) from the fall. Physician orders on the 9/8/25 hospital Discharge Summary that directed the resident's return to the facility on 9/8/25, specifically instructed staff: 1. Continue routine assessment of cognition and limit polypharmacy (use of multiple medications with same purpose) as feasible. 2. Discontinue medications with risk for falls including Gabapentin (anticonvulsant					

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	medication with analgesic properties), Tramadol (controlled narcotic analgesic) and Tizanidine (a skeletal muscle relaxer). 3. Discontinue Sertraline (antidepressant) since patient is already on Duloxetine (antidepressant). Physician orders transcribed after the resident's 9/8/25 return to the facility included: 1. Tramadol 50 milligrams (mg) administered oral 4 times a day, order reinstated on 9/11/25 and continued through 10/24/25. 2. Sertraline 100 milligrams (mg) administered oral daily, order reinstated on 9/12/25, order for Fluoxetine was discontinued. 3. Gabapentin 300 mg administered oral 3 times a day, order reinstated on 9/25/25 and continued through 10/24/25. And the facility initiated new medication orders that increased the resident's risk for falls that included: 1. Melatonin (a hormone with sedative/hypnotic properties) 5 mg			

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	administered oral daily at bedtime, order started 9/11/25. 2. Ramelteon (a Melatonin receptor agonist, to enhance the effects of Melatonin) 8 mg administered oral daily at bedtime, order started 9/8/25. The resident's record revealed from the 20 falls previously mentioned in this document, 7 of the 20 occurred between 9/13/25 and 10/24/25, with 3 of the 7 unwitnessed and occurred in the resident's room. On 9/13/25 at 6:50 a.m., the resident was found on the floor in his room with walker beside him, frank bleeding from bridge of nose with laceration present. Hospitalized until 9/14/25 with diagnoses that included fall, nasal laceration and subdural hematoma. On 10/24/25 at 7:26 a.m., the resident was found on the floor in his room, on his back next to the bed, pillow under head, blanket on top of him. Pupils unequal in size and non-reactive to light (abnormal finding). Sent to hospital and transferred to a tertiary hospital where he remained in an intensive care unit at the time of this investigation, with diagnoses that included right 6th through 10th rib fractures, pneumo/hemothorax (collapsed lung/lung filled with blood), acute compression fracture of the 10th			

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	thoracic vertebrae and right greater tuberosity fracture (shoulder). Interviews with the resident's family and Power of Attorney (POA) revealed: 11/4/25 at 4:25 p.m., a family member stated the resident had many repeated falls while at the facility and injured several times. The facility staff does not listen to their family in regards to the resident's safety, they have asked for fall interventions such as moving him closer to the center of the building, fall mats, and someone to sit with him to provide 1 to 1 supervision when needed and the facility has not done any of those things, he continued to fall and currently hospitalized because of a fall. The family member stated they had not been invited to participate in a care conference or care plan meeting for the resident and that would be an opportunity to have some input for his safety. 11/4/25 at 5:08 p.m., the POA stated the resident was still hospitalized for the injuries from his most recent fall at the facility, and thought the resident was overdosed or received too much sedative medication and that was why he had so many falls. They visited the resident 1 day in September and he slept sitting up in a chair from 10:11 a.m. to 3:45 p.m. During that time period staff did not			

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	wake him up for lunch or any other purpose. The POA stated they didn't think the resident received the care that he needed and they haven't done much to prevent his falls. The POA denied that they had been invited to participate in the resident's care conferences or care plan meetings, and when they tried to ask staff about the reasons for his falls, if the falls could be related to his medications the nurse said the doctor ordered his medication and he had to have it. Staff interviews revealed: On 11/5/25 at 5:31 a.m. Staff A LPN (Licensed Practical Nurse), stated she worked the night shift and knew the resident well. During the night time the resident usually stayed in his room, with the door shut, he wanted the door shut and insisted on that. Staff tried to check on him as they were able to during the night, they had to be careful because he would get angry if they woke him up. Staff A stated a fall matt placed on the floor in his room would be a tripping hazard for the resident and would cause a fall, as the resident got up on his own spontaneously. They did try to keep an eye on him at night, but it was difficult with his door shut. On 11/5/25 at 1:13 p.m., Staff B, LPN, stated she usually worked the 6 a.m. to 6 p.m. day shift, knew the resident well, he didn't understand his physical			

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	limitations and that contributed to many of the falls that he had, he wanted to be independent. He'd been having problems with his left foot/ankle hurting a lot, that effected how he could bare weight and thought that had also contributed to his falls. When he's in his room he insisted that the door remain shut, it was hard to know when he was up as he would get himself up and didn't call for assistance. When asked if she thought a baby monitor placed in his room to monitor for sound could help staff know when he was getting up or starting to move around Staff B thought that was a good idea, staff could listen and have a better chance of get into his room and assist him before he fell or was unsteady on his feet. Staff D, CNA (Certified Nursing Assistant) and Staff E, CNA were interviewed together on 11/5/25 at 5:38 a.m., both stated they regularly worked on the night shift and knew the resident well. He slept in his bed in his room, and wanted his door kept shut. He could get up independently and did so, he used his call light sometimes, and sometimes he called with his phone if he wanted something. They tried to check on him when they did rounds, around every 2 hours, they had to be careful not to wake him and it was difficult to open his door without waking him. He could get agitated if they woke him up during the night.				

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	11/5/25 at 8:40 a.m., Staff C, CNA, stated she usually worked on the day shift but also worked during the evening, knew the resident, he wanted to be independent, he let you know if he needed or wanted help which wasn't very often. Sometimes he would let her put his support hose on. If you tried to help him, he would get upset/angry and wouldn't accept the assistance. He was supposed to use a walker, sometimes he would forget it and they were supposed to remind him to use it, he got angry sometimes when they did that. When he was in his room, he wanted his door closed and he didn't want to be disturbed. Staff G, Director of Nursing (DON), interviewed 11/5/25 at 8:27 a.m. stated she had been the DON there since June, 2025, knew the resident well, he was stubborn, but he was alert and oriented. When he was hospitalized after a fall in September the hospital took away all his psych medications and that made his mood/agitation/behaviors worse. The resident would sit in the common areas throughout the day to "people-watch" as he was very social, and staff could watch him that way as he only went to his room to use the bathroom or to lay down. When he was in his room with the door closed, staff were supposed to check on him when they did rounds, every couple hours. The resident was very independent and he did not want			

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	assistance, he was vocal about that and would become agitated. 11/5/25 at 1:03 p.m. Staff F, Activity director stated when resident's are due for care conferences she identified who the resident's responsible parties were, met with the resident and asks if they wanted them to participate in their upcoming care conference and if so she invited them. Each time she met with Resident #4 he didn't want his family to participate in his care conferences and they had not been invited to them. 11/5/25 at 3:30 p.m., the Administrator stated the resident had a sign that he made himself and had put on his door that said to keep his door shut and had an expletive on it, she removed the sign while he was in the hospital. When asked about interventions related to his falls and fall prevention, the Administrator stated they did move him to a room in a busier hallway, there's a lot of traffic in that hall related to the residents there, their care requirements and there are more observations of him that way. The DON stated she thought the problems with his left ankle and associated pain were making him more prone to falls, as weight bearing was painful and every time they had an appointment with an orthopedic physician for him to get it taken care of he'd have another fall or hospitalized and they had to reschedule the appointments. The resident had hardware in his			

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	ankle that required adjustment during a surgery in order to resolve the problem and the resident wanted to have that surgery. The Administrator and DON did not have a response when asked specifically about what had been done to increase the direct supervision of the resident related to his falls, as many of the falls occurred when the resident was in his room with the door closed, and staff allowed the resident to keep the door closed. FACILITY RESPONSE			

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