

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES


PRINTED: 03/31/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165381</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>03/24/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>STONE COTTAGE CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>900 SOUTH STONE STREET SIGOURNEY, IA 52591</b>
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<p>F 000 ✓ ok/CP</p> <p>F 550 SS=D</p>	<p><b>INITIAL COMMENTS</b> <b>Correction Date: April 2, 2025</b> The following deficiencies relate to the investigation of Facility Reported Incident #126678-M conducted on March 19, 2025 to March 24, 2025.</p> <p>This self-report was investigated by a representative of this Department. The release of information regarding allegations of Dependent Adult Abuse is governed by Code of Iowa 235B.6(2) and Chapter 235B.(6)3. The findings for the alleged abuse will be sent under a separate cover letter.</p> <p><b>Resident Rights/Exercise of Rights</b> CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p>	<p>F 000</p> <p>F 550</p>		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>4/2/25</b>	(X6) DATE
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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.

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F 550	<p>Continued From page 1</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews, the facility failed to ensure a resident's right of choice and self determination regarding their health care needs for 1 of 3 residents reviewed. (Resident #1) The facility reported census was 26.</p> <p>Findings include:</p> <p>According the Quarterly Minimum Data Set (MDS) with a reference date of 2/20/24, Resident #1 had a Brief Mental Status (BIMS) score of 11 which indicated a moderately impaired cognitive status. Resident #1 required maximal assistance with transfers, mobility, dressing, toilet use and personal hygiene needs. Resident #1 was coded as always incontinent of bladder and continent bowel. Resident #1's diagnosis included cerebrovascular accident (stroke), hemiplegia, renal insufficiency and seizure disorder.</p>	F 550			

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F 550	Continued From page 2  In an interview on 3/20/25 at 1:33 p.m.. Staff B, Certified Nurse Aide (CNA), stated she was working an overnight shift on 1/20/25. It was after 10:00 p.m. and she and Staff E, CNA, had just cleaned and prepared Resident #1 for bed and had exited his room when Staff A, Licensed Practical Nurse (LPN), approached her saying Resident #1 needed a suppository since not having a bowel movement for 3 days. Staff B stated they returned to Resident #1's room and she asked Resident #1 if it was okay to get a suppository. Resident #1 stated no, clearly. Staff B stated this all happened as they were rolling Resident #1 onto his side. Staff A was saying something and Staff B stated she was unaware at that time that Staff A had a suppository in his hand. It all happened quickly and Resident #1 began swinging at Staff A as he administered the suppository. Afterwards, Staff B stated she apologized to Resident #1 and encouraged him to report what happened to the Director of Nursing (DON). Staff B stated she later talked to the DON when a similar incident happened (1/26/25).  In an interview on 3/20/25 at 1:55 p.m. Staff C, Certified Nurse Aide, stated she was working a double shift (2:00 p.m. to 10:00 p.m.) on the evening of 1/26/25. There was discussion regarding Resident #1 not having a bowel movement for 4 days. Staff A stated Resident #1 needed a suppository and instructed Staff C to accompany him to Resident #1's room. Staff C stated she followed Staff A into Resident #1's room as instructed. Staff A explained to Resident #1 that it was necessary for a suppository. Resident #1 was adamant that he did not want the suppository. Staff A informed Resident #1 that we're going to give one and Staff C assisted	F 550			

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F 550	<p>Continued From page 3</p> <p>in rolling Resident #1 onto his side and Staff A administered the suppository. Staff C stated she felt uncomfortable with the situation and on Monday, 1/27/25, she reported her concern to management.</p> <p>In an interview on 3/20/25 at 12:07 p.m. the Director of Nursing (DON) stated on the morning of 1/26/25, she was making rounds and asked Resident #1 how he was doing. Resident #1 stated last night he was given a suppository against his will. Resident #1 stated he had not had a bowel movement the past few days and Staff A insisted he needed a suppository. Resident #1 stated this was not the first time this has happened. The DON stated she began looking into what happened and called Staff A, who admitted he gave the suppository despite Resident #1 saying no. The DON stated residents have a choice which needs to be respected. The DON stated it is the overnight nurse's responsibility to address bowel movement issues. Point Click Care (PCC) will alert when a resident has not had a bowel movement for 3 days. The DON stated the nurse should follow standard practice by using Milk of Magnesia on day 3 without a bowel movement and a suppository on day 4. The DON stated resident refusals of care or administration of medications should be addressed by the interdisciplinary team.</p> <p>In an interview on 3/24/25 at 1:30 p.m. Staff A, Licensed Practical Nurse, stated on Saturday, 1/25/25 he was working the overnight shift from 6:00 p.m. to 6:00 a.m. That evening Resident #1 was complaining of constipation and a stomach ache. Staff A looked up Resident #1's bowel movement record and it had been four days since</p>	F 550			

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F 550	Continued From page 4 his last bowel movement. Staff A stated nurses are supposed to initiate an intervention after the 3rd day. Staff A stated between 8:00 p.m. and 9:00 p.m. Resident #1 was refusing oral medications and becoming increasingly agitated. Resident #1 was offered a suppository and refused, stating you only want to give me a suppository since I'm black. Staff A stated this was typical behavior when Resident #1 is in pain or discomfort. Staff A stated he attempted to explain why he needed the suppository and he would feel better once he had a bowel movement, but Resident #1 remained angry and obstinate. Between 10:00 p.m. and 11:00 p.m. Staff A attempted to assess Resident #1, but was denied. At 11:45 p.m. Staff A was allowed to listen to Resident #1's bowel sounds. They were sluggish and it was now day 4, so Staff A felt it was his duty to ensure Resident #1 received care to relieve his constipation and to prevent further discomfort and complications. Staff A summoned Staff C to assist. Resident #1 was placed on his left side and started getting agitated stating no, no. Staff A stated he perceived the "no" related to his stomach discomfort. Staff A stated he stopped and attempted to re-explain the dangers of possible bowel obstruction or perforation. Staff A stated Resident #1 seemed to calm down and he quickly inserted the suppository. Within the next two hours, Resident #1 had two large bowel movements. The following evening when Staff A returned to work, Resident #1's daughter was visiting. Resident #1 expressed appreciation for the suppository, saying thank you and that he was feeling much better. Staff A stated Resident #1 is like that. When he is in pain or discomfort, he becomes agitated, racial and unable to think things through. Once he gets the suppository and has the bowel movement, he's fine. Staff A	F 550			

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F 550	<p>Continued From page 5</p> <p>stated Resident #1 had received another suppository on 1/20/25. He was agitated that day also, but primarily upset with the suppository taking too long to work.</p> <p>In an interview on 3/24/25 at 2:30 p.m. Resident#1 was queried if he ever had to use a suppository for constipation? Resident#1 responded yes and stated the LPN Staff A made him take a suppository and he did not want to. Resident#1 stated some time ago he was angry and LPN, Staff A wanted to give him a suppository. The Resident said he told Staff A no, but he gave him one anyway. Resident#1 was asked if he felt better afterwards and he stated yes.</p> <p>According to progress notes dated 1/20/25 at 10:27 p.m. Resident #1 was administered a suppository by Staff A. A follow up note on 1/21/25 at 5:04 a.m. indicated Resident #1 was feeling better following the suppository.</p> <p>According to the Medication Administration Record for January 2025, a suppository was administered to Resident #1 on 1/25/25 at 11:42 p.m. by Staff A.</p>	F 550			

Plan of Correction for Stone Cottage Care Center Provider# 165381

Date: March 19-24, 2025

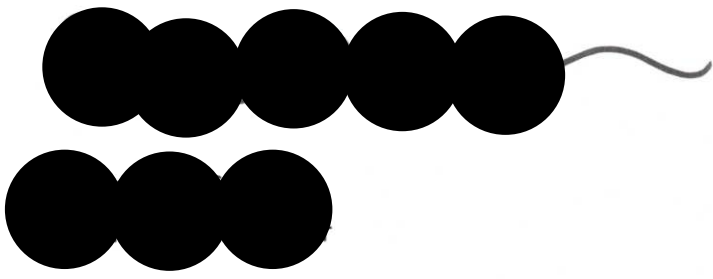
Plan and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with State and Federal Law.

F 550: Resident Rights

- The facility does ensure a resident right of choice and self-determination regarding their health care needs.
- Staff member on suspension was educated regarding resident rights and self-determination of their health care needs on 3.27.25 and returned to work.
- All staff have been educated on resident rights and self-determination of their health care needs on 4.2.25.
- ADMIN/DON/Designee will perform audits regarding resident rights and self-determination regarding their health care needs weekly x 4, then monthly x 2 with results discussed at QA meeting for further review of continued compliance.

Compliance: April 2, 2025

Responsible Party: Admin/DON/Designee

The signature area is redacted with black circles. The first row contains five circles, with a wavy line extending from the right side of the fifth circle. The second row contains three circles.