STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165404	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Specialty Care	100 Care Circle Street Po Box 136, New London, Iowa, 52645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 ✓ KG	INITIAL COMMENTS Correction date: 7/16/26 The following deficiencies resulted from investigation of complaints #2965122-C, #2988558-C and facility reported incidents #2807881-I, #3034780-I and #2982333-M conducted June 9, 2026 to June 15, 2026. Complaint #2965122-C resulted in a deficiency. Complaints #2988558-C did not result in a deficiency. Facility reported incidents #2807881-I, #2982f333-M and #3034780-I resulted in deficiencies. Findings for facility reported incident #2982333-M will be sent to the facility at a later date under separate cover. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000	"Preparation and/or execution of this plan of correction does not constitute admission or agreement bythis provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law."	
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, clinical record review, facility policy review, provider and staff interview the facility	F0689	1: Resident #6 no longer resides in facility. 2: Current residents requiring transfer assistance have the potential to be affected. 3: The facility has implemented the following system changes: Facility nursing staff educated on following proper transfers including the use of equipment such as gait belts. 4: The Director of Nursing (DON) or designee will complete 3 transfer observations per week, for 4 weeks, then (continued)	

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 reverse for further 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
BC Donahue	Administrator	7/16/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165404	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Specialty Care	**100 Care Circle Street Po Box 136, New London, Iowa, 52645**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = G	Continued from page 1 failed to use a gait belt during a transfer for 2 of 2 (Resident #6 and Resident #5) residents at risk for a fall, with Resident #6 experiencing a fall which resulted in a fracture and the need for a surgical repair. The facility reported a census of 43 residents. Findings include: 1. Review of Resident #6's the Minimum Data Set (MDS) assessment tool dated 1/30/26, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. The diagnoses list included acute and chronic respiratory failure with hypoxemia (low oxygen level in the blood), diabetes, congestive heart failure and morbid obesity. The MDS assessed Resident #6 required substantial/maximal staff assistance for transfers to and from bed or chair, and repositioning in bed. The MDS identified the resident utilized a walker, wheelchair and supplemental oxygen. Review of Resident #6's Care Plan revealed the following problems: a. I am at risk for falls initiated 1/26/2026. Interventions included: 1. Encourage me to use my call light for assistance, initiated 1/26/2026. 2. Encourage me to wear proper footwear, initiated 1/26/2026. 3. I need a safe environment without clutter, initiated 1/26/2026. 4. Implement two-person assist until therapy can evaluate resident after fall, initiated 3/19/2026. 5. Move oxygen concentrator closer to the restroom prior to ambulating me to bathroom, initiated 3/26/2026. 6. Provide me with long O2 (oxygen) tubing in order to ambulate to the bathroom safely, initiated 3/26/2026. 7. PT/OT evaluation and treat as ordered, initiated 1/26/2026. b. Activities of Daily Living (ADL's) problem initiated 1/26/2026. Interventions included, in part: 1. Ambulation/Mobility - I am an assist of 2 for transfers using four wheeled walker (FWW) and gait belt, initiated 1/26/2026, revised 3/19/2026.	F0689	2 monthly for 2 months, then as needed. Identified concerns will be reviewed by the facility's QAPI committee. Completion Date: 7/8/26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165404	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Specialty Care	100 Care Circle Street Po Box 136, New London, Iowa, 52645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = G	Continued from page 2 Review of the electronic health record (EHR) revealed the following Progress Note entered on 3/26/26 at 3:45 AM: CNA called this nurse to resident's room. Upon entering this nurse found resident lying on her left side in the doorway of her bathroom. 4WW was in the bathroom in front of resident. Resident states she lost her balance. CNA staff states resident was turning to sit on the toilet and her oxygen (O2) tubing snagged due to being too short. CNA staff turned and attempted to pull O2 tubing closer and resident fell backwards onto the floor. Resident states she hit her head and her left elbow. Rates left elbow pain 10/10 and is unable to move left arm without pain. Resident is alert and oriented. Resident moves all other extremities with no pain. Vital signs BP 180/88, HR 89, RR 20, Temp 97.3, 02 94% on 2L via nasal cannula. Provider notified and ordered the resident's transfer to the hospital Emergency Room. Review of the facility self-reported incident submitted 3/26/2026 revealed, in part: Incident Summary: Resident fall with fracture…Corrective Action Description: Admitted to higher level of care…Left humerus fracture. I turned to sit on the toilet and lost my balance and fell backward. I hit my head and elbow on the floor. Document review: BIMS 15, Admit 2/13/26. After 3/19/26 resident [name redacted, Resident #6] was to be assisted by 2 staff until she could be evaluated by therapy…Resident discharged from facility on 3/26/26. Did not return… [name redacted, Resident #6] was skilled and receiving PT (physical therapy) and ST (speech therapy). Therapy did not change her assistance level. Through the investigation, we determined that [name redacted, CNA (Certified Nursing Assistant)] was not using a gait belt for transfer… Review of a [hospital name redacted] Discharge Summary dated 4/7/26 revealed, in part: Diagnoses: Fracture of distal end of left humerus…Summary of Events Leading to Admission…Patient is a 64-year-old female who presented to the emergency department after a mechanical fall…Per patient she was being assisted at her nursing facility to go to the bathroom when her oxygen tubing became tangled on her feet. Per resident she tried to help staff untangle herself when she lost her balance fell mainly on her left side. Per resident she mainly stroke her left elbow and her head…CT (computed tomography – type of x-ray, often called a CAT scan) of left upper arm with results of highly comminuted and displaced fracture (a bone break where bone shatters into three or more pieces, fragments separate and move out of	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165404	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Specialty Care	**100 Care Circle Street Po Box 136, New London, Iowa, 52645**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = G	Continued from page 3 their normal alignment) of distal humerus, bones osteopenia (low bone density), no joint dislocation, extensive tissue swelling. Orthopedic surgeon consulted who recommended surgical intervention. Patient has agreed to undergoing surgery… Staff interviews revealed: a. 6/11/26 at 7:15 a.m. Staff I, CNA stated the resident's oxygen reached the bathroom without a problem, the resident was a mechanical lift transfer at times, staff were supposed to check the communication book when they get to work for any changes, and can also check the Kardex (a quick summary of resident needs in the electronic clinical record) for the resident's care requirements. b. 6/15/26 at 2:30 p.m. Staff E, CNA stated Resident #6 was a 1 person assist for transfer the last time she had worked with her prior to 3/26/26. Staff E stated when she got to work for the night shift that started at 10 p.m. on 3/25/26 she did not review the communication book and her gait belt was in her car and she didn't think to get it out of her car that night. Staff E stated she transferred Resident #6 by herself that night, without a gait belt. She explained Resident #6's oxygen tubing got caught on furniture and when she pulled on the tubing to free it Resident #6 fell. c. 6/11/26 at 8:58 a.m. Staff G, interim Director of Nursing (DON) stated the resident's transfer method changed to 2 staff assist with gait belt and walker on 3/19/26, the change was recorded in their communication book that all staff were required to read and sign. Staff G stated Staff E had not signed the communication book when she worked on 3/26/26. Staff G stated the aides were expected to have and use their gait belts, and to follow resident care plans. d. 6/15/26 at 1:15 p.m. the Administrator stated Staff E, CNA was terminated because she failed to follow the facility's policy for resident transfers and use of the gait belt. 2. Review of Resident #5's MDS assessment dated 5/7/26 revealed a BIMS score of 13 out of 15 indicating intact cognition. The diagnoses list included vascular dementia, peripheral vascular disease (poor circulation), diabetes and weakness. The MDS indicated the resident independently used a walker and required substantial staff assistance to reposition in bed, transfer to and from bed and chair, and from chair to chair.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165404	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Specialty Care	100 Care Circle Street Po Box 136, New London, Iowa, 52645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = G	Continued from page 4 Review of Resident #5's Care Plan dated 8/28/24, revealed a Focus area to address Activities of Daily Living (ADL's). Interventions included, in part: Transfer - Resident is assisted of 1 for all transfers in room with CGA for safety with FWW. Offer to ambulate Resident to lunch daily with assist of 1, gait belt, Front Wheeled Walker, and CGA with wheelchair following. Ambulate resident as far as she can tolerate to the lunch room. I may refuse, initiated 11/09/2025. During an observation on 6/11/26 from 6:53 a.m. to 7:04 a.m., while Resident #5 in her bed, Staff O, CNA provided morning care and prepared to transfer the resident out of bed. After assisting the resident to get dressed and apply a prosthetic on her left lower leg, Staff O assisted Resident #5 to sit on the side of the bed with the wheelchair positioned next to the bed. Staff O stated the resident transferred with 1:1 and a stand pivot. Without a gait belt, Staff O assisted Resident #5 to stand while supporting the resident from under the residents arms. The resident grabbed the armrests of her wheelchair and held them as she turned. Staff O directed the resident to turn to her left, take a few steps to turn and then sit in the wheelchair. Resident #5 transferred to the wheelchair without incident. After the transfer Staff O asked if she used a gait belt for the transfer, and she stated no, and added she used gait belts that were in residents' rooms and she did not know if there was a gait belt in Resident #5's room. During an interview on 6/11/26 at 8:52 a.m., Staff G, interim Director of Nursing (DON) and Staff A, RN and MDS nurse asked about Resident #5's transfer observed at 6:52 a.m., stated Staff O, CNA should have used a gait belt as directed. Review of the facility policy titled Safe Lifting and Movement of Residents revised July 2017, revealed a Policy Statement which declared: In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. The Policy Interpretation and Implementation section directed, in part: 2. Manual lifting of residents shall be eliminated when feasible. 3. Nursing staff, in conjunction with rehabilitation staff, shall assess individual residents needs for transfer assistance eon a ongoing basis, Staff will document resident transferring and lifting needs in	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165404	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Specialty Care	**100 Care Circle Street Po Box 136, New London, Iowa, 52645**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = G	Continued from page 5 the care plan… 4. Staff responsible for direct resident care will be trained int eh use of manual (fait/transfer belts, lateral boards) and mechanical lifting devices. 7. Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques.	F0689		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.	F0580	1: Resident # 7 no longer resides in facility. 2: Current residents have the potential to be affected. 3: The facility has implemented the following system changes: Licensed staff have been educated on timely notification of change to the provider when there is a change in condition, such as a fall. 4: The Director of Nursing (DON) or designee will complete weekly 3 records will be reviewed for timely notification of change to the Provider for three weeks, monthly for 2 months, then as needed. Identified concerns will be reviewed by the facility's QAPI committee. Completion Date: 7/16/26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165404	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Specialty Care	**100 Care Circle Street Po Box 136, New London, Iowa, 52645**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0580 SS = D	Continued from page 6 (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, facility policy review and staff interview the facility failed to notify the primary care provider of a fall in a timely manner for 1 of 3 (Resident #7) reviewed for change in condition. The facility reported a census of 43 residents. Findings include: Review of Resident #7's Minimum Data Set assessment dated 2/12/26 revealed a diagnoses list which included dementia, diabetes with neuropathy, and acute osteomyelitis (bone infection) of left ankle. The Brief Interview for Mental Status score of 9 out of 15 indicated a moderate cognitive impairment. Review of the [name of hospital redacted] Progress Notes dated 3/9/26 revealed, in part: Assessment and Plan: #s/p (status post) fall, #nondisplaced (stable) fracture of left superior pubis ramus (upper front bone of pelvis). Patient fell from wheelchair. ED physician spoke to orthopedics, recommended conservative management, weightbearing as tolerated and outpatient follow-up… Review of Resident #7's Care Plan dated 11/17/25, revealed a Problem area to address I am at risk for falls. The facility's Falls-Clinical Protocol policy, dated as revised March, 2018 directed, in part: a. The staff will evaluate and document falls that occur while the individual is in the facility.	F0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165404	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Specialty Care	**100 Care Circle Street Po Box 136, New London, Iowa, 52645**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0580 SS = D	Continued from page 7 b. The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. Review of a Nurses Note in the electronic health record (EHR) dated 3/7/26 at 11:10 p.m. revealed: Late Entry: Upon arriving to the facility nurse noticed res yelling out in pain while sitting in recliner in the common area. The current nurse [name redacted] report to the writing nurse on the resident at 22:30 (10:30 p.m.). [name redacted] reported the res had a fall at 2000 (8:00 p.m.), she had notified family, PCP (primary care provider), and facility manager. There was a skin tear on R (right) forearm that [name redacted] had cleaned, placed steri strips and island dressing. After telling PCP res was in extreme pain and could not move right leg he reordered to send res out. The writing nurse had called for transfer via ambulance and called [name of hospital redacted] ER (emergency room) to give report on resident. Later in the shift writing nurse called to receive report on res and was reported by [name redacted, RN (Registered Nurse)] he had a fracture and was waiting for therapy evaluation to have him admitted. Review of the EHR view Progress Note for Nurses dated 3/7/26 at 11:10 p.m., revealed a Created Date of 3/13/26 11:27 p.m., by Staff J, Licensed Practical Nurse (LPN). Review of an Incident, Accident, Unusual Occurrence Note in the EHR dated 3/8/26 at 8:51 p.m., revealed: Late Entry: Summary: Resident observed on floor. Resident assisted to recliner safely. Assessment done and Neuro checks initiated. VSS (vital signs stable). RN gently assessed bilateral hips and bilateral extremities for pain or discomfort. At baseline, resident had limited ROM (range of motion) and pain in RLE (right lower extremities). Resident denied any pain at this time. RN notified Provider and residents son, [name redacted]. Resident started complaining of pain in RLE and was unable to get comfortable. RN notified Provider; resident was sent out to local ED (emergency department) for further evaluation. Review of the EHR view Progress Note for the Incident, Accident, Unusual Occurrence Note dated 3/8/26 at 8:51 p.m. revealed a Created Date of 3/21/26 1:16 p.m. by Staff K, Registered Nurse (RN). During an interview on 6/10/26 at 4:53 p.m. Staff J, Licensed Practical Nurse (LPN) stated she worked the night shift 10 p.m. to 6 a.m. that started on 3/8/26. When she got to work at 10 p.m. Resident #7 was in the recliner in the common area by the TV and yelled about pain in his leg. Staff J recalled,	F0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165404	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Specialty Care	100 Care Circle Street Po Box 136, New London, Iowa, 52645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0580 SS = D	Continued from page 8 Staff K was the nurse on duty for 2 p.m. to 10 p.m., and when he [Resident #7] yelled Staff K was taking his vital signs. Staff J stated Staff K, RN reported to her the resident fell and she [Staff K] did not realize the resident had been hurting until she started moving him. Staff J recalled Staff K stated the resident had pain with the transfer after the fall but it has subsided once she put him in the recliner. Staff J stated she thought the resident should have already been sent out for evaluation and helped Staff K with what needed to be done to get him sent out. Staff J explained for a fall the nurse on duty should document the fall, assessment and the actions taken. She added the nurse is required to assess the resident, if is an unwitnessed fall start a neurological assessment with post fall vital signs, notify the provider even if there is no injury identified at the time. During an interview on 6/12/26 at 4:27 p.m. Staff K, RN stated she'd worked at the facility since November, 2025, and had been a nurse for 10 years. Staff K stated she worked the evening of that Resident #7 fall. Staff K stated when she saw the resident "he just laid there on the floor". She added she thought he was on his right side. Staff K recalled the resident did not have pain, other than his left leg and that was not new. She added he could move everything. Staff K stated two staff members got under his arms, they had a gait belt around his waist, and she was behind him and helped the 2 staff to stand him up. Staff K stated Resident #7 was able to bear weight on both legs and did not have any symptoms of pain. She stated they then pivoted him to the chair and he sat there for an hour and seemed fine. Staff K recalled the resident started to have pain and became louder about an hour later. She stated she could not remember what time he fell, but thought it was between 7:30 and 8 p.m. Staff K stated she initially messaged the facility's Nurse Practitioner (NP) and said he was uncomfortable after the fall, the NP said to monitor until morning. Staff K stated she called the NP again after the night shift nurse arrived and the NP thought the resident needed to be seen so they sent him to the hospital. Staff K recalled she completed every 15-minute checks of vital signs (VS) and neuro checks and there were no changes. She explained she did not call the family or the manager on call because she wasn't aware she was supposed to. Staff K stated she thought she started to write a note about the fall, but couldn't remember and stated she should have documented his fall and her assessments on the day it occurred. During a call on 6/15/26 at 11:52 a.m., the facility's	F0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165404	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Specialty Care	**100 Care Circle Street Po Box 136, New London, Iowa, 52645**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0580 SS = D	Continued from page 9 contracted provider network answering service stated there was no documentation of a call by the facility about Resident #7's fall on 3/8/26. During an interview on 6/15/26 at 4:23 p.m. the facility's NP stated the only call or message he received about Resident #7's fall on 3/8/26 came in at 10:28 p.m. on 3/8/26, and he directed the staff to send him out due to his pain and probable injuries, he had no notice or knowledge of the fall prior to that call. During an interview on 6/15/26 at 1:21 p.m. Staff N, RN, former DON (from mid-December, 2025 until the end of March, 2026) stated staff never called her about the resident's fall on 3/8/26, she found out the next morning when she came in to work. Staff N stated Staff K, RN was a seasoned nurse and she knew she was supposed to call the provider any time there was a fall, with or without injuries, and to also call the manager on call and the family. Staff K should have also documented about his fall that night before she left work, it was not acceptable to chart about that 2 weeks later. During an interview on 6/11/26 at 8:58 a.m. Staff G, RN, interim DON stated if a resident fell the nurse was required to assess the resident, provide care required, notify the provider even if no injury, the manager on call and the family of the fall, and document all of the information in the resident's record on the day of the fall. In an email exchange on 6/16/26 with the facility Administrator, the Administrator communicated the facility had no other documentation that the provider was notified of Resident #7's fall on 3/8/26.	F0580		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F0600	Resident #2 was evaluated at the time of the event, and no injury was determined. Current residents have the potential to be affected. The facility has implemented the following system changes: Abuse reeducation and competency checks performed for all employees. The Administrator/ Business Office Manager (BOM) or designee will complete 3 employee file audits weekly audits with new employee orientation (continued)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165404	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Specialty Care	**100 Care Circle Street Po Box 136, New London, Iowa, 52645**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 10 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, clinical record review, facility policy review, and staff and resident interviews, the facility failed to prevent a resident-to-resident incident (Resident #1 and Resident #2) which resulted in Resident #1 throwing a pack of disposable wipes at Resident #2 causing two days of discomfort. The facility reported a census of 43 residents. Findings include: Review of a facility's self-reported incident submitted 6/3/26 described a resident [Resident #1] threw a package of wet wipes in roommate's [Resident #2] direction, contact made, no injuries observed and the residents were separated. 1. Review of Resident #1 Minimum Data Set (MDS) assessment dated 4/30/26 revealed diagnosis of cerebrovascular accident (a stroke) with hemiplegia (paralysis on 1 side of the body) and depression. The Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicated a moderate cognitive impairment. The MDS indicated Resident #1 dependent on staff for all activities of daily living (ADL's) with exception of eating and oral hygiene. During an interview on 6/10/26 at 10:36 a.m., when asked about an incident with a previous roommate [Resident #2], Resident #1 stated the roommate was singing and he did not like that so he threw wipes at him. When asked if he had said anything to him before that or if he had asked him to stop singing the resident said no. 2. Review of Resident #2's MDS assessment dated 4/21/26 revealed Resident #2 diagnoses of diabetes, legal blindness, mood disorder, and post-traumatic stress disorder (PTSD). The BIMS score of 15 out of 15 indicated intact cognition. The assessment revealed the resident required limited staff supervision or touch assistance for ambulation due to severely impaired vision. Review of an Incident, Accident, Unusual Occurrence note in the electronic health record (EHR) dated 6/3/26 at 6:58 p.m. revealed: Resident was lying in bed and his roommate threw a package of wipes at him striking his chest. Resident is upset and angry	F0600	check lists weekly for 4 weeks, monthly for 2 months, then as needed. Identified concerns will be reviewed by the facility's QAPI committee. Completion Date:7/16/26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165404	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Specialty Care	100 Care Circle Street Po Box 136, New London, Iowa, 52645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 11 at the situation. Resident states he doesn't know why the roommate did it. Review of a Nursing Note entered in the EHR on 6/3/26 at 7:01 p.m. revealed Head to toe completed following incident of resident's roommate throwing a package of wipes at him. No injuries noted upon assessment. During an interview 6/10/26 at 9:50 a.m., Resident #2 he was singing when his roommate [Resident #1] threw something at him that hit him in the middle of his chest, his chest hurt for 2 days. Resident #2 stated he was caught off-guard because his roommate had not said anything to him and he couldn’t see that he’d thrown anything at him due to his blindness. Review of Resident #2’s June 2026 Medication Administration Record and Treatment Administration Record (MAR/TAR) revealed on 6/3/26 a pain of 4 documented and 650 milligrams (mg) of acetaminophen (Tylenol) oral administered as ordered by the physician for pain, with relief of pain documented. During an interview on 6/10/26 at 3:03 p.m. Staff B, Certified Nursing Assistant (CNA), stated she worked on the evening of the incident between Resident’s #1 and #2. There had been no indication that Resident #1 would do something like that. She answered Resident #2’s call light right before supper, he was very upset, said Resident #1 had thrown a package of wet wipes at him. Later that night he said his chest hurt and that his room-mate threw the wet wipe package at him because he didn’t like his singing. 6/10/26 at 3:49 p.m. Staff A, Registered Nurse (RN) stated she was on duty when Resident #1 threw a package of wet wipes at Resident #2. She assessed the resident for injury and did not see any marks or bruising on the resident. Resident #2 said he had pain in his chest where he was struck by the wipes, it was mild, she medicated him with Tylenol and that was effective. She had not seen an signs of injury since the day of the incident. Review the facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised 2021, directed that all residents had the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse,	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165404	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Specialty Care	100 Care Circle Street Po Box 136, New London, Iowa, 52645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 12 and physical or chemical restraint not required to treat the resident's symptoms. The policy directed that residents were to be protected from abuse by facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, and/or any other individual.	F0600		
F0726 SS = D	Competent Nursing Staff CFR(s): §483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, facility policy review, personnel file review and staff interviews, the facility failed to ensure that a staff who changed positions from a dietary employee to a certified nursing assistant completed orientation and	F0726	1: Current files have been reviewed for required education and competencies. 2: Current residents have the potential to be affected. 3: The facility has implemented the following system changes: Department managers have been educated regarding protocol for new hire paperwork. 4: The Administrator or designee will complete weekly (3) audits with new employee orientation check lists weekly for 4 weeks, monthly for 2 months, then as needed. Identified concerns will be reviewed by the facility's QAPI committee. Completion Date: 7/16/26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165404	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Specialty Care	**100 Care Circle Street Po Box 136, New London, Iowa, 52645**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0726 SS = D	Continued from page 13 demonstrated skill competencies prior to working independently with residents. The facility reported a census of 43 residents. Findings include: Review of a facility's self-reported incident submitted on 3/26/26 described a fall experienced by Resident #6 while being transferred without the use of a gait belt by one staff [Staff E, Certified Nursing Assistant (CNA)]. The fall resulted in fracture that required a surgical repair. Review of Resident #6 Care Plan dated 1/26/26 revealed a Focus areas to address: a. I am at risk for falls, with the Intervention: Implement two-person assist until therapy can evaluate resident after fall, initiated 3/19/2026. b. Activities of Daily Living (ADL's), with the Intervention: Ambulation/Mobility - I am an assist of 2 for transfers using four wheeled walker (FWW) and gait belt, initiated 1/26/2026, revised 3/19/2026. A review of Staff E, CNA's personnel file revealed: a. An initial hire date of 5/30/23 for the position of dietary employee. b. An undated Direct Care Worker inquiry form indicated Staff E certified as a Certified Nursing Assistant on 6/7/25, had an active status, without employment. c. A CNA Job Description form signed by Staff E on 6/20/25. d. No information found in file which indicated Staff E's start date as a CAN, completion of CNA orientation or verification of CNA competency. e. A Disciplinary Action form dated 4/2/26 described Staff E terminated as the result of failure to follow a resident's care plan and safe transfer procedures. This failure resulted in a resident fall with major injury… During an interview on 6/10/26 at 2:26 p.m. Staff F, Business Office Manager and Human Resources Director, stated she could not say when Staff E changed positions from dietary to that of a CNA. Staff F stated after the change, Staff E had still worked in the kitchen when needed. Staff F stated she does not have documentation of a CNA Skills Check List or competency assessments for Staff E	F0726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165404	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Specialty Care	100 Care Circle Street Po Box 136, New London, Iowa, 52645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0726 SS = D	Continued from page 14 as a CNA. During an interview on 6/11/26 at 8:58 a.m., Staff G, interim Director of Nursing (DON) stated she could not find any documentation of Staff E's training and not sure of her start date as a CNA. Staff G stated Resident #6's Care Plan was changed to a 2 staff transfer with gait belt and walker on 3/19/26. The change in the Care Plan was documented in their communication book that all staff were required to read and sign, Staff E had not signed the communication book when she worked on 3/26/26. Staff G added all staff were expected to follow the resident's Care Plan. Review of the facility policy titled Orientation revised October 2017, revealed a Policy Statement which declared: An orientation program is conducted for newly hired nurses aids. The Policy Interpretation and Implementation section directed, in part: 1. All newly hired nurse aides must attend an orientation program within their first 5 days of employment. 2. The orientation program includes, but is not limited to: c. An introduction to resident care procedures, which includes: A review of the facility's policies and procedures; A review of the facility's in-service training program; A review of the facility's infection control practices; Review of the facility policy titled Competency of Nursing staff revised May 2019 revealed a Policy Statement which declared: 1. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by State Law. 2. In addition, licensed nurses and nursing assistants employed (or contracted) by the facility will: a. Participate in a facility-specific, competency-based staff development and training program; and b. Demonstrate specific competencies and skill sets	F0726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165404	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Specialty Care	**100 Care Circle Street Po Box 136, New London, Iowa, 52645**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0726 SS = D	Continued from page 15 deemed necessary to care for the needs of residents, as identified through resident assessments and described in the plans of care. The Policy Interpretation and Implementation section directed, in part: 2. The following factors are considered in the creation of the competency-based staff development and training program: An evaluation of the current program to ensure basic nursing competencies; Any gaps in education or training that may be contributing to poor outcomes; Specialized skills or training needed based on the resident population; A method to track, assess, plan, implement and evaluate the effectiveness of training; and A method to evaluate critical thinking skills and management of care in complex environments with multiple interruptions.	F0726		