STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165404	A. Building B. Wing	02/26/2026

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

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, facility policy review resident and staff interviews, the facility failed to maintain room meal trays at a palatable and safe temperature for one of one meal service observed. The facility reported a census of 43 residents. Findings include: Review of Resident Council Meeting Questions for January 2026 revealed residents stated the food is not always up to temperature and breakfast trays are late and the hamburgers and waffles are usually lukewarm.During an interview on 2/23/26 at 1:07 PM, Resident #27 stated she ate breakfast in bed and the food was cold all the time. Resident #27 stated the facility needed food warmers. During an observation on 2/25/26 at 8:12 AM, rooms trays are delivered down A hall first. During an observation on 2/25/26 at 8:20 AM, a breakfast test tray was temped with Staff G, Activities Coordinator with the following results:French toast-97.5 degrees FSausage - 102.6 degrees FMilk- 47.5 degrees FDuring an interview on 2/25/26 at 9:54 AM, Resident #27 asked how her breakfast was and Resident #27 stated she only took a bite of her sausage it was less than warm. Resident #27 stated she asked the facility to warm up her food 75% of the time. Resident #27 stated the food was supposed to be warm and she wouldn't eat it unless it was warm. During an interview on 2/25/26 at 1:16 PM, Staff E, Dietary Staff queried on the process with room trays and Staff E stated dietary prepared the room trays and the Certified Nurse Aides (CNAs) delivered them. Staff E stated the CNA did not always come very quickly to pick up the trays. Staff E stated on average the trays sat for 10 minutes before the CNAs delivered the trays. Staff E asked if the residents ever mentioned the food being cold and Staff E stated it had been awhile since anyone complained about it because the facility was getting them out quicker. Staff E stated the residents said the pancakes and bread were cold and breakfast was harder to keep warm. During an interview on 2/26/26 at 9:13 AM, Staff F, [NAME] asked about the room trays and Staff F stated the dietary staff get them ready for the CNAs to pass them but sometimes the trays sit for 15 minutes before the CNAs were ready to pass them. Staff F stated the delivery part was the problem because the food temperatures were good before they trays were sent out. During an interview on 2/26/26 at 9:19 AM, the Dietary Manager informed of the temperature on the breakfast room tray on 2/25/26 and the Dietary Manager stated they tried to get staff to pass the trays on time. The Dietary Manager stated she would look into finding ways to keep the food at the required temperatures. The Dietary Manager queried what the holding temperatures needed to be for the room trays and she stated the cold items should not be over 40 degrees F and the hot food items should be 135 degrees F or above. The Facility Food Preparation and Service Policy revised on April 2019 revealedFood Preparation, Cooking and Holding Time/TemperaturesThe danger zone for food temperatures is between 41 F and 135 F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, clinical record review, facility policy review manufacturer instructions of facility equipment, and staff interviews, the facility failed to ensure 1 of 1 resident (Resident #27) transported in a wheelchair chair with feet in a safe position (Resident #27), and failed to ensure resident safety when using a mechanical sit to stand device for 1 of 1 resident (Resident #27). The facility reported a census of 43 residents. Findings include: Review of the Minimum Data Set (MDS) assessment, dated 1/22/26 revealed Resident #27 scored a 9 out of 15 on the Brief Interview for Mental Status (BIMS) exam, a moderate impairment of cognition. The list of diagnoses of non-Alzheimer's dementia, generalized muscle weakness, and unspecified lack of coordination included. The MDS indicated Resident #27 dependent for most transfers, used a manual wheelchair and dependent to wheeling 150 feet in the corridor. Review of the Care Plan revealed the following Focus areas:a. Activities of Daily Living (ADL's), dated 8/28/24 which included Interventions, in part: Transfer - I am a hoyer (a brand name for a mechanical lift) for all transfers except for toilet transfers. I am a stand eaze (also called ezstand or EZ stand a type of lift that assists the resident from a sitting to a standing position and after secured they propelled to the desired location) with assist of 2 for toileting transfers, initiated 3/5/25. b. I am risk for falls, dated 8/28/25 with an Intervention Do not leave me resident alone in the bathroom, initiated 1/2/26. c. I have impaired cognitive function/dementia or impaired thought processes related to my diagnosis of vascular dementia, revised 5/15/25 with an Intervention Provide cues, re-orient and supervise as needed, initiated on 9/10/24. Review of a document titled Unwitnessed Fall, Date 1/2/26 at 5:00 PM revealed a Nursing Description: Staff nurse heard faint yelling, CNA (Certified Nursing Assistant) went to check down the hallway to check resident rooms, CNA called for nurse. Upon entering shower room the resident was observed on the floor in a sitting position with Ezstand sling under arms, still attached to ezstand. Resident was assessed for injuries, none noted. VSS (vital signs stable). Resident was cleaned and hoyered to wheelchair. Neuro check started. PCP notified. Family notified. Education to staff done. The Notes section revealed RCA (Root Cause Analysis): left alone on EZ stand in bathroom. Intervention: do not leave alone in bathroom. On 2/25/26 at 3:31 PM, Staff A, Registered Nurse (RN) queried on the incident [1/2/26] with Resident #27 in the bathroom and Staff A stated after staff notified her of the incident, she went to the whirlpool bathroom and found the resident on the floor. Staff A described the resident had the mechanical sit to stand under him, and it was still attached to him. Staff A stated the lift should have not been attached to the resident. When asked if is standard practice to leave a resident alone with the lift attached, Staff A stated she did not think it was acceptable to leave the resident alone. Staff A explained her understanding was if the brakes were on, residents could be left alone in the whirlpool room still attached to the mechanical sit to stand.On 2/26/26 at 8:50 AM, when asked if a resident could be hooked up to the EZ stand while on the toilet, Staff B, CNA stated yes, some residents wanted to stay hooked up to the machine, but Staff B always locked the wheels and gave the resident a call light. Staff B stated staff needed to stay with Resident #27 as he may fall asleep or try to grab at the machine. Staff B stated staying with Resident #27 is not new and staff needed to always stay with him as it was not safe to leave him alone. During an interview on 2/26/26 at 11:01 AM, Staff C, CNA queried on leaving residents in the mechanical sit to stand in the bathroom and Staff C stated that was how she was trained but the lift needed to be fully down and the wheels locked. Staff C stated she would not leave Resident #27 alone because she would be afraid Resident #27 would try to get up or fall.During an interview on 2/26/26 at 11:34 AM, Staff D, CNA queried on the incident [1/2/26] with Resident #27 and Staff D stated she helped another aide get Resident #27 into the mechanical sit to stand and take him into the whirlpool room to use the bathroom. Staff D stated she asked the aide if they needed help with giving Resident #27 the call light or locking the brakes and the aide said no, so Staff D left. Staff D stated a little (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	while later, a nurse said she heard yelling and sent the CNAs to walk up and down the halls to find it. Staff D explained she did not hear the yelling so she continued to chart. Staff D stated when she did hear the yelling, she asked another CNA if they got Resident #27 off the toilet. Staff D explained the aide said no so she went to the whirlpool room and found Resident #27 on the floor. Staff D described finding Resident #27 with his bottom on the ground, the stand not in the same place when she left the room earlier, and the residents' arms were around the sling, holding them up. Staff D explained in the past she had left Resident #27 in the whirlpool room alone with the wheels locked. Staff D stated she would then set a timer for 5 minutes to remind herself to check on him. Staff D added she did not know how long Resident #27 was in the bathroom by himself.During an observation on 2/25/26 at 12:32 PM, Staff B, CNA propelled Resident #27 in his wheelchair from the dining room towards his room. During the transport, Resident #27 feet were positioned outside of the foot pedals and slide across the dining room floor. Resident #27 informed Staff B he needed to use bathroom. Staff B turned Resident #27 around and propelled him in his wheelchair down Hallway B towards a bathroom. Resident #27 feet remained out of the foot pedals and slide across the floor. During an interview on 2/25/26 at 3:31 PM, Staff A, RN stated residents' feet should be on the wheelchair foot pedals when they are pushed. During an interview on 2/26/26 at 8:50 AM, Staff B, CNA queried on where a resident's feet needed to be when pushed in a wheelchair and Staff B stated on the foot pedals. Staff B stated some residents didn't like to put their feet on foot pedals and staff would have to remind the residents. Staff B stated Resident #27 didn't like to put his feet on the foot pedals and Staff B would have to put them on 3 or 4 times.During an interview on 2/26/26 at 12:13 PM, the Director of Nursing (DON) stated she was not working at the DON at the facility when the incident on 1/2/26 occured. The DON stated yes, residents could be left attached to the mechanical sit to stand in the bathroom with a call light and the brakes locked. The DON stated Resident #27 is directable and listens and maybe he was confused when it happened. The DON stated the CNAs know what residents they can leave alone in the bathroom. The DON asked if the mechanical sit to stand could be moved with the brakes on, and the DON stated yes, it would take some effort. The DON asked where feet should be when a resident is being pushed in the wheelchair and the DON confirmed feet should be on the foot pedals.After requested on 2/26/26, the facility stated they do not have a policy regarding the use of wheelchair foot pedals. Review of an undated facility policy titled Lifting Machine, Using a Mechanical Policy revealed a Purpose statement which declared The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training or instructions. The policy did not address resident supervision needs.Review of the EZ Way Smart Stand Operator's Instructions, revised 5/9/25 instructed in part:a. Lower the patient (page 6)1. When lowering the patient onto a chair, toilet, wheelchair or bed, the caregiver should stand beside the patient.2. Press the down button on the hand control until the patient is fully lowered.b. Unhook harness (page 7)1. When the patient securely seated, lower the stand arm until there is enough slack to unhook the harness loops from the arm. Unhook the loops.2. Move the unit away from the patient.3. Unfasten the buckle that was across the patient's torso. Remove the harness from behind the patient by grasping the center harness handle.