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	FCL017064	A. BUILDING: _____ B. WING _____	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HORIZONS	1111 YARBOROUGH ROAD MILTON, NC 27305

(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) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section completed an annual and follow up survey on 06/20/24.	C 000		
C 131	10A NCAC 13G .0403(a) Qualifications of Medication Staff 10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF (a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure that 2 of 3 sampled staff (Staff A, Staff B) who administered medications had completed the state-approved 5-hour,10-hour, or 15-hour medication aide (MA) training courses and the Medication Administration Competency Validation Clinical Skills Checklist as required. The findings are: 1. Review of Staff A's, MA, personnel record revealed: -There was documentation of Staff A passed the MA written exam on 05/04/24. -There was no documentation Staff A completed the Medication Administration Competency Validation Clinical Skills Checklist -There was no MA employment verification form	C 131		

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for Staff A.
-There was no documentation Staff A completed the state-approved 5-hour, 10-hour, or 15-hour MA training courses.

Review of residents' medication administration records (MAR) for April 2024, May 2024 and June 2024 revealed Staff A had administered medications to the residents on multiple occasions.

Interview with Staff A on 06/20/24 at 3:10pm revealed:
-He was hired in March 2024.
-He administered medications to the residents.
-He did not know about the 5-hour, 10-hour, or 15-hour state approved MA training course and had not completed it.
-He had not completed the Medication Administration Competency Validation Clinical Skills Checklist.

Interview with the Administrator on 06/20/24 at 3:30pm revealed:
-The Registered Nurse (RN) from the pharmacy came to the facility to provide the state approved MA 5-hour, 10-hour, or 15-hour training and complete the Medication Administration Competency Validation Clinical Skills Checklist.
-She had not completed the Medication Administration Competency Validation Clinical Skills Checklist for Staff A.
-He thought Staff A had completed the required state approved MA 5-hour, 10-hour, or 15-hour training course but could not locate the training certificates.

2. Review of Staff B's, MA, personnel record revealed:
-There was documentation Staff B passed the MA

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C 131	Continued From page 2 written exam on 11/07/14. -There was no documentation Staff B completed the Medication Administration Competency Validation Clinical Skills Checklist. -There was no MA employment verification form for Staff B. -There was no documentation Staff B completed the state-approved 5, 10-hour, or 15-hour MA training courses. Review of residents' medication administration records (MAR) for April 2024, May 2024 and June 2024 revealed Staff A had administered medications to the residents on multiple occasions. Attempted interview with Staff B on 06/20/24 at 3:15pm was unsuccessful. Interview with the Administrator on 06/20/24 at 3:30pm revealed: -The Registered Nurse (RN) from the pharmacy came to the facility to provide the state approved MA 5-hour, 10-hour, or 15-hour training and complete the Medication Administration Competency Validation Clinical Skills Checklist. -She had not completed the medication skills checklist for Staff B. -He thought Staff B had completed the required state approved MA 5-hour, 10-hour, or 15-hour training course but could not locate the training certificates. _____ The facility failed to ensure staff who worked as a MA and administered medications to residents completed the 5 hour, 10 hour, or 15-hour training course before administering medications resulting in medication errors. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.	C 131		

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C 131	Continued From page 3 _____ The facility provided a plan or correction in accordance with G.S. 131D-34 on 06/20/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 08/04/24. [Refer to 10A NCAC 13G .1004(a) Medicaion Administration]	C 131		
C 148	10A NCAC 13G .0406 (a)(8) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 1 sampled staff (Staff B) had an examination and screening for the presence of controlled substances completed upon hire. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired on 04/05/24. -There was no examination and screening for the presence of controlled substances available. Attempted telephone interview with Staff B on 06/21/24 at 3:10pm was unsuccessful.	C 148		

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C 148	Continued From page 4 Interview with the Administrator on 06/21/24 at 3:20pm revealed: -All staff had to have a drug screen upon hire. -Staff B administered medications to the residents. -Staff B did not have a drug screen in his personnel record. -He thought Staff B had a drug screen upon hire. -He was responsible for ensuring drug screens were completed on all new hires.	C 148		
C 252	10A NCAC 13G .0903(a) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (a) The facility shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan, and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, TED hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents;	C 252		

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C 252	Continued From page 5 (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy. For the purpose of this Rule, "well-established colostomy or ileostomy" means having a healed surgical site without sutures or drainage; (10) care for pressure ulcers, up to and including a Stage II pressure ulcer, which is a superficial ulcer presenting as an abrasion, blister, or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube. For the purpose of this Rule, "well-established gastrostomy feeding tube" means having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established; (15) medication administration through subcutaneous injection in accordance with Rule .1004(q) except for anticoagulant medications; (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include endotracheal suctioning. For the purpose of this Rule, "well-established tracheostomy" means the stoma is well-healed and the airway is patent; (20) administering and monitoring of tube feedings through a well-established gastrostomy feeding tube in accordance with Subparagraph (a)(14) of this Rule; (21) the monitoring of continuous positive air	C 252		

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C 252	Continued From page 6 pressure devices (CPAP and BIPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic devices except as used in post-operative treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises; (26) any other prescribed physical or occupational therapy; (27) transferring semi-ambulatory or non-ambulatory residents; or (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that Act in 21 NCAC 36. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure the assessment and evaluation by a licensed health professional for 1 of 2 sampled residents (#1) who had orders for oxygen. The findings are: Review of Resident #1's current FL-2 dated 05/02/24 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), emphysema, nicotine dependence, and mild asthma. -There was an order for oxygen 4 liters	C 252		

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C 252	Continued From page 7 continuously. Review of Resident #1's record revealed there was no licensed health professional support (LHPS) assessment and evaluation. Observation of Resident #1's room on 06/21/24 at 9:15am revealed: -There was an oxygen concentrator in the room at the end of the bed. -The oxygen concentrator was turned on and set at 4 liters. Interview with Resident #1 on 06/21/24 at 3:00pm revealed he used oxygen when he was in his room. Interview with a registered nurse (RN) from the facility's contracted pharmacy on 06/21/24 at 10:50am revealed: -She was responsible for completing the LHPS assessments and evaluations. -She had not completed the LHPS assessment and evaluation on Resident #1. -The Administrator was supposed to let her know when there was a new admission. -The Administrator let her know Resident #1 was admitted to the facility, but it was late and she could not complete the LHPS assessment and evaluation in time. Interview with the Administrator on 06/21/24 at 11:15am revealed: -Resident #1 did not have a LHPS assessment and evaluation completed. -He was responsible for calling the RN to let her know there was a new admission that needed to have a LHPS assessment and evaluation. -He did let the RN know Resident #1 was admitted to the facility, but it was not in time to	C 252		

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C 252	Continued From page 8 have the LHPS assessment and evaluation completed in 30 days.	C 252		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to clarify orders for 1 of 2 sampled residents (#1) including 2 bronchodilators, and 2 corticosteroid inhalers. The findings are: Review of Resident #1's current FL-2 dated 05/02/24 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), emphysema, asthma, and nicotine dependence. -There was an order for ipratropium 0.5mg; the order did not include how often to administer the medication. -There was an order for fluticasone 250mcg; the order did not include how often to administer the	C 315		

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medication.
-There was an order for trelegy ellipta 200mcg; the order did not include how often to administer the medication.
-There was an order for albuterol inhaler; the order did not include how often to administer the medication.

Review of Resident #1's medication administration record (MAR) for May 2024 revealed:
-There was no entry for ipratropium 0.5mg.
-There was no entry for fluticasone 250mcg.
-There was no entry for trelegy ellipta 200mcg.
-There was no entry for albuterol inhaler.

Review of Resident #1's medication administration record (MAR) for 06/01/24 to 06/20/24 revealed:
-There was no entry for ipratropium 0.5mg.
-There was no entry for fluticasone 250mcg.
-There was no entry for trelegy ellipta 200mcg.
-There was no entry for albuterol inhaler.

Observation of Resident #1's medications on hand on 11:30am revealed:
-Ipratropium 0.5mg was not available to administer.
-Fluticasone 250mcg was not available to administer.
Trelegy ellipta 200mcg was not available to administer.
Albuterol inhaler was not available to administer.

Interview with Resident #1's Primary Care Provider (PCP) on 06/20/24 at 11:00am revealed:
-When Resident #1 was admitted, there was confusion with his medication orders.
-She contacted Resident #1's previous PCP and got the medication orders clarified.

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C 315	Continued From page 10 -She completed another FL-2 for Resident #1 on 05/15/24 but it did not get faxed to the pharmacy. -Resident #1 needed to be on all of his inhalers listed on the FL-2 (ipratropium, fluticasone, trelegy ellipta, and albuterol) because he had emphysema, COPD, and was a smoker. Interview with the Administrator on 06/20/24 at 11:15am revealed: -He faxed the FL-2's to the pharmacy for new admissions. -If there were incomplete orders on the FL-2's, the PCP should be contacted for clarification and clarification sent to the pharmacy. -He was not aware there was a new FL-2 for Resident #1 that needed to be faxed to the pharmacy.	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 2 sampled residents (#1 and #2) including 2 bronchodilators, and 2 corticosteroid inhalers (#1), and a topical	C 330		

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pain medication (#2).

The findings are:

1. Review of Resident #1's current FL-2 dated 05/02/24 revealed diagnoses including chronic obstructive pulmonary disease (COPD), emphysema, schizophrenia, nicotine dependence, and mild asthma.

Review of Resident #1's Resident Register revealed Resident #1 was admitted to the facility on 05/10/24.

a. Review of Resident #1's current FL-2 dated 05/02/24 revealed:
-There was an order for ipratropium 0.5mg used to treat bronchospasms associated with COPD.
-The order did not include instructions for how often to administer the medication.

Review of Resident #1's May 2024 medication administration record (MAR) revealed there was no entry for ipratropium 0.5mg.

Review of Resident #1's MAR for 06/01/24 to 06/20/24 revealed there was no entry for ipratropium 0.5mg.

Observations of Resident #1's medications on hand on 06/20/24 at 10:30am revealed there was no ipratropium 0.5mg available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 06/20/24 at 12:34pm revealed:
-Ipratropium was a medication used to treat bronchospasms in COPD.
-Resident #1's FL-2 dated 05/02/24 included an order for ipratropium 0.5mg.

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C 330	Continued From page 12 -The order for ipratropium 0.5mg did not include instructions for how often to administer the medication. -The pharmacy contacted the facility to clarify the order but did not receive it. -Ipratropium 0.5mg had not been dispensed from the pharmacy. b. Review of Resident #1's current FL-2 dated 05/02/24 revealed: -There was an order for fluticasone 250mcg used to help prevent the symptoms of asthma. -The order for fluticasone 250mcg did not include instructions for how often to administer the medication. Review of Resident #1's May 2024 MAR revealed there was no entry for fluticasone 250mcg. Review of Resident #1's MAR for 06/01/24 to 06/20/24 revealed there was no entry for fluticasone 250mcg. Observation of Resident #1's medications on hand on 06/20/24 at 10:30am revealed there was no fluticasone 250mcg available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 06/20/24 at 12:34pm revealed: -Fluticasone 250mcg was an inhaler used to treat COPD. -Resident #1's FL-2 dated 05/02/24 included an order for fluticasone 250mcg but did not include how often to administer the medication. -The pharmacy contacted the facility for clarification but did not receive it. -The fluticasone 250mcg was never dispensed by the pharmacy.	C 330		

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C 330	Continued From page 13 c. Review of Resident #1's current FL-2 dated 05/02/24 revealed: -There was an order for trelegy ellipta 200mcg used to prevent bronchospasms in COPD. -The order for trelegy ellipta 200mcg did not include instructions for how often to administer the medication. Review of Resident #1's May 2024 medication administration record (MAR) revealed there was no entry for trelegy ellipta 200mcg. Review of Resident #1's MAR for 06/01/24 to 06/20/24 revealed there was no entry for trelegy ellipta 200mcg. Observations of Resident #1's medications on hand on 06/20/24 at 10:30am revealed there was no trelegy ellipta available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 06/20/24 at 12:34pm revealed: -Trelegy ellipta was an inhaler used to treat COPD. -Resident #1's FL-2 dated 05/02/24 included an order for trelegy ellipta 200mcg but did not include how often to administer the medication. -The pharmacy contacted the facility for clarification but did not receive it. -The trelegy ellipta 200mcg was never dispensed by the pharmacy. d. Review of Resident #1's current FL-2 dated 05/02/24 revealed: -There was an order for albuterol sulfate inhaler used to treat shortness of breath. -The order for albuterol sulfate inhaler did not include instructions for the dosage or how often to	C 330		

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	FCL017064	A. BUILDING: _____ B. WING _____	06/20/2024

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NEW LIFE HORIZONS	1111 YARBOROUGH ROAD MILTON, NC 27305

(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) COMPLETE DATE
C 330	Continued From page 14 administer the medication. Review of Resident #1's May 2024 medication administration record (MAR) revealed there was no entry for albuterol sulfate inhaler. Review of Resident #1's MAR for 06/01/24 to 06/20/24 revealed there was no entry for albuterol sulfate inhaler. Observations of Resident #1's medications on hand on 06/20/24 at 10:30am revealed there was no albuterol sulfate inhaler available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 06/20/24 at 12:34pm revealed: -Albuterol inhaler was used to treat COPD. -Resident #1's FL-2 dated 05/02/24 included an order for albuterol inhaler but did not include the dosage or how often to administer the medication. -The pharmacy contacted the facility for clarification but did not receive it. -The albuterol inhaler was never dispensed by the pharmacy. Interview with Resident #1 on 06/20/24 at 3:00pm revealed: -He had COPD and emphysema. -He was a smoker. -He used oxygen all the time except when he went out to smoke. -He did not have any shortness of breath. -He did not use any inhalers; he used to but did not anymore; he did not think he needed them. Interview with the MA on 06/20/24 at 3:10pm revealed:	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 330	Continued From page 15 -He administered medications to Resident #1. -He did not have any inhalers on hand to administer to Resident #1. -He did not know Resident #1 had orders for inhalers. -He did not do anything with the residents FL-2's when they were admitted, the Administrator took care of all of that. -Resident #1 had not experienced shortness of breath or difficulty breathing. -If Resident #1 had shortness of breath, he would keep him calm and call 911. Interview with Resident #1's PCP on 06/20/24 at 11:00am revealed: -When Resident #1 was admitted to the facility, there was a lot of confusion about his medications. -She got in touch with Resident #1's previous PCP and got clarification of his medications. -The Administrator was responsible for making sure the FL-2's and the clarification orders were faxed to the pharmacy. -She was not aware Resident #1 did not have his prescribed inhalers. -Resident #1 had COPD, asthma, and emphysema and needed the inhalers to keep his airway open and manage symptoms. -She was concerned Resident #1 had not received his medications as ordered. -Each inhalant medication Resident #1 had ordered acted to treat and manage his COPD, emphysema, and asthma. -Not having the medications ordered could result in closed airways and respiratory distress. -To her knowledge, Resident #1 did not have any symptoms of respiratory distress. Interview with the Administrator on 06/20/24 at 11:15am revealed:	C 330		

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C 330	Continued From page 16 -It was his responsibility to fax FL-2's for new residents to the pharmacy. -He faxed Resident #1's FL-2 to the pharmacy. -He contacted Resident #1's PCP for clarification for the inhaler orders. -He thought Resident #1's PCP would clarify the orders and send them to the pharmacy. -He did not follow up to ensure Resident #1 received his medications from the pharmacy. -He was not aware Resident #1 did not have his ordered inhalers. -He had not noticed Resident #1 in respiratory distress. 2. Review of Resident #2's current FL-2 dated 05/01/24 revealed diagnoses including unspecified mood disorder, hypertension, hyperlipidemia, and depression. Review of a physician's order dated 06/07/24 revealed a new order for voltaren gel four times a day to affected area (right shoulder, right and left knee) as needed Review of Resident #2's June 2024 medication administration record (MAR) revealed there was no entry for voltaren gel four times a day to affected area as needed. Observation of Resident #2's medications on hand on 06/20/24 at 10:30am revealed there was no voltaren gel available to administer for Resident #2. Telephone interview with a representative with the facility's contracted pharmacy on 06/20/24 at 12:26pm revealed: -The pharmacy did not have an order for voltaren gel for Resident #2. -The facility should fax the orders to the	C 330		

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C 330	Continued From page 17	C 330		

pharmacy.
-The facility should have added the voltaren gel to the MAR.
-Voltaren gel was used to treat pain and inflammation.
-Voltaren gel had not been dispensed for Resident #2.

Interview with Resident #2 on 06/20/24 at 1:20pm revealed:
-She had pain daily in her back, right knee and shoulder.
-Her pain level was an 8 out of 10.
-She did not know her primary care provider (PCP) ordered voltaren gel.
-She thought the medication might be helpful.

Interview with the medication aide (MA) on 06/20/24 at 11:30am revealed:
-Resident #2 did not have voltaren gel available to administer.
-Voltaren gel was not on Resident #2's MAR.
-He did not fax orders to the pharmacy; he thought the Administrator did that.
-He was not aware Resident #2 should receive voltaren gel as needed.
-Resident #2 had complaints of pain sometimes.

Interview with Resident #2's PCP on 06/20/24 at 11:00am revealed:
-Resident #2 had a healed humorous fracture and had chronic pain.
-Resident #2 had asked her for something for pain so she ordered the voltaren gel for her to try.
-She wrote the order for the voltaren gel and expected the facility to fax the order to the pharmacy.
-She was not aware the pharmacy did not receive the order for the voltaren gel and Resident #2 did not have the voltaren gel available.

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C 330	Continued From page 18 Interview with the Administrator on 06/20/24 at 11:15am revealed: -He was not sure why the order for voltaren gel for Resident #2 did not get faxed to the pharmacy. -He thought the PCP would have faxed the order to the pharmacy. -He did not follow up to make sure new orders were carried out. -He was responsible for the residents and making sure they had the medications ordered. The facility failed to administer medications as order for 2 of 2 sampled residents including a resident with a history of COPD and emphysema and orders for short and long acting inhalers and a steroidal inhaler which resulted in an increased risk of closed airways and respiratory distress (#1); and a resident with a history of a humerous fracture and chronic pain with an order for an anti-inflammatory and an analgesic gel which resulted in increased risk of worsening pain (#2). This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/20/24. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED August 4, 2024.	C 330		