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Division	of Health Service Re	egulation			
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		FCL017064	D. WING		05/14/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
NEW LIE	E HORIZONS	1111 YAR	ROROUGH	ROAD	
	LIIOINEONO	MILTON,	NC 27305		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT: CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE COMPLETE HEAPPROPRIATE DATE
C 000	Initial Comments		C 000		
	Caswell County De	ensure Section and the partment of Social Services all survey and complaint by 14, 2025.			
C 100	10A NCAC 13G .03 Disaster Plan	316 (e) Fire Safety And	C 100		
	10A NCAC 13G .03 Plan	316 Fire Safety And Disaster		·a , C.	
	fire evacuation plat rehearsals shall be furnished to the co services annually, date and time of th	at least four rehearsals of the n each year. Records of maintained and copies unty department of social. The records shall include the e rehearsals, staff members at description of what the		There is a fire a conducted 3) times it is necessated book maintained, it	Cheansal 5/19/25 s quarterly 5/19/25 r placed in a n the facility
	Rased on observat reviews, the facility evacuated the facility was activated within 2 of 3 residents. The findings are: Review of the facility bepartment of Health certificate revealed. The facility's licenter the facility is lice	se was issued on 01/01/25. sed capacity was 6 ambulatory		oletector, but more all Rehears all whe recorded in the book. As the a I will continue that all Staff Lesidents will be	detector, + fixedrill dministrator,
		DEMOUPPLIER REPRESENTATIVE'S SIC	Links	by Norliner Ho	Aministrator 5/28/2
STATE FOR	RM		6899	XW1011	If continuation sheet 1 of 35

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Division o	f Health Service Re	gulation	(Y2) MITTER F	CONSTRUCTION	(X3) DATE	FTED	
CTATEMARNI	OF DEFICIENCIES	(X1) PROVIDENSUPFLIENCE. IDENTIFICATION NUMBER:	A. BUILDING: _				
AND PLAN	OF CORRECTION	IDENTIFICATION TOTAL	A. Bolconto.		·		
					05/1	4/2025	
		FCL017064	B. WING		1 001.		
			DRESS, CITY, ST	TATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER					Ì	
		1111 YAR	BOROUGH R	OAD			
MEAN FILL	EHORIZONS	ani Ton,	NC 27305	PROVIDER'S PLAN	OF CORRECTION	(X5)	
	CUMBAARV ST.	ATEMENT OF DEFICIENCIES	ID	CAPE CORRECTIVE A	CTION SHOULD BE	COMPLETE	
(X4) IV		** Little T DE DRECEDED 13 15 1 11 UEC	FRESIX	CROSS-REFERENCED T	O THE APPROPRIATE	1,,,,,,	
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	IAG	DEFICIE	NGY)		
Į						1	
C 100	Continued From pa	age 1	C 100			i	
0 100		J.					
	residents.					1	
		disation aida				İ	
	Interview with the	- Charge (SIC) on 05/14/25 at					
	(MA)/Supervisor-in	n-Charge (SIC) on 05/14/25 at the current census was 3					
	8:05am revealed t	tie current census was o					
	residents.						
	Daview of the faci	lity's undated policy on fire				1	
! 	safety revealed:	ity's dilucted pointy on the	1			1	
	The fire and dies	ster plan was reviewed with	ļ			ļ	
	each resident folk	wing admission	and the second s				
	Circ drille were or	onducted monthly, were			•		
	-File dillis were or	d at various times in the month					
	and at varying tim	es of the day to include normal					
	sleep time.	, do 0, and 1-1, and					
	-Residents and st	aff were to treat the fire drill as					
	though the fire dri	Il were an actual fire; new	Í			ĺ	
ļ	residents would b	e oriented to the fire drill					
	procedure on the	day of admission					
	piooddaib vii iii-	,		}			
İ	Review of the fac	ility's fire drill form revealed:					
	On 02/24/25 at 6	:30pm, a fire drill was				Ì	
1	conducted, all 3 r	esidents evacuated the facility,	ł				
	and evacuation ti	me was 1 minute.					
		:45pm, a fire drill was					
1	conducted, all 3 r	esidents evacuated the facility,					
l	and evacuation ti	me was 1 minute.	**************************************			4	
	On 04/24/25, at 6	:37pm, a fire drill was	ļ			:	
	conducted, all 3 r	esidents evacuated the facility,					
		me was 35 seconds.	e consession				
		fire drill conducted on 05/14/25					
	at 8:20am-8:22ar					- [
	177444 11414	ale residents in one resident				İ	
		resident was in her bed.					
		vated the smoke alarm.					
	, .	esidents left his room and exite	d				
	the facility.					Ì	
		e resident remained in his bed.				Approximation of the control of the	
	│ -The female resid	fent remained in her bed.					

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TO. :19197339379

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING: ___ B. WING FCL017064 05/14/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

4444 VARROROUGH ROAD

NEW LIFE HORIZONS			1111 YARBOROUGH ROAD MILTON, NC 27305		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF (EACH DEFICIENCY MUST BE PI REGULATORY OR LSC IDENTIFY	DEFICIENCIES RECEDED BY FULL	ID PREFIX IAC	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS_REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
C 100	Continued From page 2		C 100		
	-When the smoke alarm was the second male exited his re outside the facility.				
	Interview with the male residence 9:53am revealed: -He heard the smoke atarm to no one had told him to loaveThe facility had fire drillsWhen the staff "hollered, fire the facility.	oday, 05/14/25, but the facility.			
	Interview with the female resi	dent on 05/14/25 at			
	-She heard the smoke detect 05/14/25The facility staff did not use fire drillsThe facility staff did not tell h when she heard the smoke a -VVnen they had fire drills, the residents to go outside.	the smoke alarm for er to go outside larm.			
	Interview with a MA/SIC on 0 revealed: -He told the residents when the had not used the smoke fire drill.	here was a fire drill.	int A soon		
	Interview with the Administrate 2:49pm revealed: -He was always at the facility conducted.				
	-He was made aware yesterd should use the smoke detect fire drills.	or when conducting			
	-He was telling residents it w residents knew what to do. -He had not practiced a fire of				
	detector or told the residents	what to do since he			!

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Division (of Health Service Re	gulation			T	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL017064	B. WING		05/1	4/2025
NAME OF F	ROVIDER OR SUFFLIER	OTRETAL	DERECC, CITY, ST	CATE, ZID CODE		
NEW LIF	E HORIZONS		RBOROUGH RONC 27305	OAD		
(X4) İÜ PREFIX IAĞ	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAC	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS.REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
C 100	Continued From pa	ige 3	C 100			
	was told on 05/13/2	25.				
C 131	10A NCAC 13G .04 Medication Staff	403(a) Qualifications of	C 131			
	10A NCAC 13G .04 MEDICATION STA	FF				
	medications, herea aides, and their din training, clinical ski written examination	me staff who administer Ifter referred to as medication ect supervisors shall complete ils validation, and pass the as set forth in G.S.				
	occupational licens	ns authorized by state sure laws to administer sempt from this requirement.				American to Control of the Control o
	This Rule is not m TYPE B VIOLATIO	et as evidenced by: N				
	reviews, the facility sampled (A), who	tions, interviews, and record / failed to ensure 1 of 3 staff administered medications, had ation aide written exam.				
	The findings are:					
	Review of the facil Policy (undated) re	ity's Medication Administration				
	-The medication a	ide (MA) would need to the written standardized test Department of Health Service				The state of the s
Annual designation of the second seco	RegulationOnly a qualified N	A designated by the ld administer medications.				
	Review of Staff A's record revealed: -Staff A's hire date	s, medication aide, personnel was 06/25/24.				man Library, tr

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	SURVEY	
		FCL017064	B. WING		05/1	4/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
NEW LIFE HORIZONS 1111 YARI		30ROUGH R	OAD			
MILTON, P		VC 27305				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 131	Continued From pa	ე≏ <u>4</u>	C 131			
C 131	-Staff A completed on 07/03/24Staff A was validat Administration Clinion 07/03/24There was no doct and passing the MAINTERVIEW with two revarious times between Staff A administered at the facility. Review of residents medication adminis 05/01/25-05/14/25 could not be determ Staff A. Interview with Ctaff revealed: -He administering revealed: -He administering revealed: -He started back we 2025 or February 2-He was scheduled which he thought well-revealed	the 15-nour MA training course ed via the Medication ical Skills Validation Checklist umentation of Staff A taking A written exam. esidents on 05/14/25 at een 9:00am-11:00am revealed dimedications when he worked is March 2025-May 2025 stration records (MARs) from on 05/14/25 revealed that it nined which initials belonged to A on 05/14/25 at 4:30pm medications when he worked, the MA written exam because hospital (2024), orking at the facility in January				
	revealed:	,	!			: :
	passed the MA write- Once she had che	ecked a MA off on the e MA was told they had 60				
L.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1		<u> </u>	<u></u>		

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If continuation sheet 5 of 35

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(X3) DATE SURVEY

Division of	Health Service Re	egulation	(X2) MULTIPLE	CONSTRUCTION	COMPLETED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING:.		
AND PLAN O	FCORRECTION	IDEM IN COLUMN			05/14/2025
		Language and the second	B. WING		03/1-4/20
		FCL017064		TIP CORE	
		STREET ADI	DRESS, CITY, S	TATE, ZIP CODE	1
NAME OF P	ROVIDER OR SUPPLIER	1111 YAR	BOROUGH F	(OAU	
ALEXAL LIFE	HORIZONS	MILTON,	IC 27305	PROVIDER'S PLAN OF COR	RECTION (X5) COMPLETE
MEAN THE		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO. (EACH CORRECTIVE ACTION	SHOULD BE COMPLETE
(X4) ID	SUMMARY ST	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	APPROPRIATE
PREFIX	REGULATORY OR	LSC IDENTIFYING INFORMATION			
TAG			0.424	CI OC a nugation	in has been
<u> </u>	Continued From p	nage 5	C 131	Start in gales	il Rosse -localed
i C 131 i	Countined Lious k	A STATE OF THE STA	1	I A DO GO	TOWN C. MINNEY
<u> </u>	-Staff A should no	t be on the medication call		mmania Meds dispensing Meds	until The
	administering me	dications until he had passed		dispensing	chentaken
	the MA written ex			Med Tech exam he	County
	Intendent with the	Administrator on 05/14/25 at	1	Med tech example apassed Moving	tokunko
			.]	all staffer pote	itial statt
	-Staff A told him	: he took the MA written exam and	1	will take a fass	the Hed
	distant noce			will take the	as d'apposine
	-He thought Staff	f A had taken the MA written		tech exam beto	econstruction of
	Jovann in March 2	¹ 025.		Will take a factor feets exam before meds in the factor of the administrate	o! litur 15
	He had been m	onitoring Staff A on the		meas in 1 100 ta	
	medication cart,	but not every medication pass. v Staff A could not be on the		the administrate	or, Luit
	-He did not know medication cart.	V Stall A Could not be on the		ensupe of this	Deactice
İ	wedication carr			ENSUME TO THEIR	President
1	The facility failer	to ensure 1 of 3 medication	Ì		
	i sides compled t	net the mustifications to			
	administer medi	cations to residents. Stall A hav			
	The second section is a section of the second section of the section of the second section of the	seed the medication aloe wille	11)		
İ	່ວາວການທ່ຽນເກວີນ	DAVA OF THE CAR NO COMMUNICIPAL OF			!
	Ladminister medi	ications to all residents in the			
	facility after 60 (days of hire and not taking and	A. C. C. C. C. C. C. C. C. C. C. C. C. C.		
	passing the writ	ten exam. The facility's failure	e		A A PLANTAGE
	was detrimental	I to the health, safety, and welfar and constitutes a Type B	-	Para Anna	
	Violation.	and constitutes a type -			
	Violation.				
	The facility prov	vided a plan of protection in			**
	accordance with	h G.S. 131D-34 on 05/14/25 for		ł	
İ	this violation.			į	
				1	
	CORRECTION	DATE FOR THE TYPE B			
	1	ALL NOT EXCEED JUNE 28,			
	2025.			t a region	
1			C 257		:
C 2		3 .0904(a)(1) Nutrition and Food	C 257		
	Service				- A
	104 11040 101	3 .0904 Nutrition and Food Servi	re l		A. C. C. C. C. C. C. C. C. C. C. C. C. C.
	10A NCAC 130	MISC DOO'T DHE HOIRIDH PUEU, C	55	,	
i	1	·			

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(X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING FCL017064 05/14/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1111 YARBOROUGH ROAD **NEW LIFE HORIZONS** MILION, NO 27005 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY C 257 Continued From page 6 C 257 (a) Food Procurement and Safety in Family Care Homes: (1) Food services shall comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, open took a preparation, and serving food under sanitary conditions. behind all staff ensuring compliance will this Rule. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the refrigerator was free from contamination, including expired food, food not labeled and dated, and debris in the drawer with raw vegetables. The findings are: Review of the Environmental Health Inspection report dated 01/09/24 revealed: -No thermometer was observed in the refrigerator. -The facility currently had no residents, and staff were reminded that a thermometer had to be placed in the refrigerator before residents moved Review of the Environmental Health Inspection

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NAME OF PROVIDER OR SUPPLIER NEW LIFE HORIZONS MILTON, NC 27305 PROVIDER OR SUPPLIER		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUII DING	LE CONSTRUCTION	(X3) DATE S	
NEW LIFE HORIZONS			FCL017064	B. WING		05/14	1/2025
MILTON, NC 27305 MACH Mach Mac	NAME OF F	PROVIDER OR SUPPLIER			·		
PREFIX TAC REGULATORY OR US DISPITE/FING INFORMATION) C 257 Continued From page 7 report dated 05/14/25 revealed: -Total demerits were 6No thermometer was observed in the refrigerator. Observation of the refrigerator on 05/14/25 at 8.08am and 4:00pm revealed: -There was a pack of pork chops dated as used by 05/05/25There was a non-reusable jug labeled as tea that had a red liquid insideAt 4:00pm, the non-reusable jug had been filled with waterThere was a container of macaroni salad purchased from the deli that had been opened; there was no label with the date openedThere was a container of potato salad purchased from the deli that had been opened; there was no label with the date openedThere was a scond bottle of salad dressing with an expiration date of 03/17/25There was a scond bottle of salad dressing with an expiration date of 03/17/25There was a scond former with cucumbers and tomatoes and tomatoes and two bags of salad mixThe was a second drawer with cucumbers and tomatoes and tomatoes and two bags of salad mixThe linside of the drawer contained dark brown juices at the bottom of the drawerAll the shelves had dried substances splattered on them and crumbs of food. Interview with the medication aide (MA)/Supervisor-in-Charge (SIC) on 05/14/25 at	NEW LIF	E HORIZONS			ROAD		
-There was a pack of pork chops dated as used by 05/05/25. -There was a non-reusable jug labeled as tea that had a red liquid inside. -At 4:00pm, the non-reusable jug had been filled with water. -There was a container of macaroni salad purchased from the deli that had been opened; there was no label with the date opened. -There was a container of potato salad purchased from the deli that had been opened; there was no label with the date opened. -There was a container of potato salad purchased from the deli that had been opened; there was no label with the date opened. -There was a bottle of salad dressing with an expiration date of 10/16/24. -There was a second bottle of salad dressing with an expiration date of 03/17/25. -There was a drawer with tomatoes and cucumbers; the inside of the drawer had various food crumbs/particles, splatters, and stains. -There was a second drawer with cucumbers and tomatoes and two bags of salad mix. -The inside of the drawer contained dark brown juices at the bottom of the drawer. -All the shelves had dried substances splattered on them and crumbs of food. Interview with the medication aide (MA)/Supervisor-in-Charge (SIC) on 05/14/25 at	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
3:46pm revealed: -Staff took turns cleaning the refrigeratorHe had not noticed the expired salad dressingsHe had just come to work today, 05/14/25, and when he went into the refrigerator, he would have		report dated 05/14/ -Total demerits wer -No thermometer was refrigerator. Observation of the 8:08am and 4:00pm -There was a nack by 05/05/25There was a non-thad a red liquid ins -At 4:00pm, the nor with waterThere was a conta purchased from the there was no label -There was a contafrom the deli that he label with the date -There was a secon an expiration date of 1-There was a secon expiration date	25 revealed: e 6. vas observed in the refrigerator on 05/14/25 at in revealed: of pork chops dated as used reusable jug labeled as tea that ide. in-reusable jug had been filled ainer of macaroni salad a deli that had been opened; with the date opened. ainer of potato salad purchased ad been opened; there was no opened. a of salad dressing with an 0/16/24. Ind bottle of salad dressing with of 03/17/25. It with tomatoes and side of the drawer had various les, splatters, and stains. Ind drawer with cucumbers and bags of salad mix. If awer contained dark brown of the drawer. If dried substances splattered be of food. Interview of the drawer of the drawer. It dried substances splattered be of food. Interview of the drawer of the drawer. It dried substances splattered be of food. Interview of the drawer of the drawer. It dried substances splattered be of food. Interview of the drawer of the drawer. It dried substances splattered be of the drawer.	C 257	Thek was a therm in the freezer but no Reshigerator. A new- moneter was punc a placed in there	ometer of the there- haved eferen	5/88/25

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Division	of Health Service Re	egulation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		FCL017064	B. WING		05/1	4/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY,	STATE, ZIP CODE		
NEW LIF	E HORIZONS	1111 YARE MILTON, N	BOROUGH F	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 257	Continued From pa	_	C 257			
C 259	Interview with a sec 3:47pm revealed: -He cleaned the ref when he worked or be cleanedThe staff were responsively water was put in the Interview with the A 2:49pm revealed: -Staff were responsively refrigeratorThe refrigerator sh more often if neede All foods should be Staff should look a was no expired foothe did not know the containers could not 10A NCAC 13G .09 Service 10A NCAC 13G .09 Service 10A NCAC 13G .09 Service 10A NCAC 13G .09 Service 10A NCAC 13G .09 Service 10A NCAC 13G .09 Service	rigerator every other week when he noticed it needed to ponsible for labeling the date and time. was washed thoroughly, and e jug. dministrator on 05/14/25 at sible for cleaning the nould be cleaned monthly or ed. e labeled when opened. It the label to make sure there d. It the label to make sure there d. It the label and reused. 204(a)(3) Nutrition and Food 204 Nutrition and Food Service ent and Safety in Family Care at three-day supply of d a five-day supply of d in the facility based on the	C 259	The Refr. general was cleaned weekly as a superior Two ensured is done a instructed by all	oillbe the ili staff	5/28/29
	for both regular and purpose of this Rul is likely to spoil or o	in Paragraph (c) of this Rule, d therapeutic diets. For the e "perishable food" is food that decay if not kept refrigerated at heit or below, or frozen at zero				

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Division	of Health Service Re	egulation			
STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY
		FCL017064	B. WING		05/14/2025
			L	ATTE TO CODE	00/14/2020
NAME OF E	PROVIDER OR SUPPLIER		BOROUGH	STATE, ZIP CODE	
NEW LIF	E HORIZONS	MILTON, N		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
C 259	food" is food that c	ige 9 t or below and 'non-perishable an be stored at room not likely to spoil or decay	Ç 259	After Shapping, inc non-perishable for purchased to mee extra food reavir a stored in the food Astho Crallity as I will continue	acility, duinoteator, to acti-
	Based on reviews, the facility failed to non-perishable foo the menus in the fa	et as evidenced by: observations, and interviews, have a 5-day supply of ds based on the census and acility, as evidence of the food ed food items stored.		on to the non-posteck pile.	eris hable.
	Observations of the facility on 05/14/25 -There were 3 can- labeled as one ser -There was a 2-po- were 18 one-fourth -Thore was 1 can- 3.5 one-half cup ser -There were 2 can- and each can was canThere was 1 can- cheese sauce labeled as 2.5 one- There were 2 can-	und bag of dried beans; there a-cup (dry) servings per bag. of lime beens with a serving of arvings. Is of beefaroni in tomato sauce, labeled as one serving per of spaghetti in tomato and alled as one serving. of cream of chicken soup			

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Division	of Health Service Re	egulation				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		FCL017064	B. WING		05/1	4/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
			BOROUGH RO			
NEW LIF	E HORIZONS	MILTON,	NC 27305			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
C 259	Continued From pa	ige 10	C 259			
	-There was 1 can of soup labeled as 2.3 -There was 1 can of -There were 12 ind -There were 12 ind orangesThere were 2 cont Review of the facilit week revealed: -On Monday, 1/2 of servedOn Tuesday, 1/2 of servedOn Wednesday, 1/2 of be servedOn Thursday, 1/2 of servedOn Thursday, 1/2 of servedOn Thursday, 1/2 of served.	of condensed chicken noodle of condensed chicken noodle of one-traif cup servings. If sliced water chestnuts, ividual cups of diced peaches, ividual cups of mandarin ainers of peanut butter. Ity's breakfast menu for one up of prune juice was to be up of apricot nectar was to be 22 cup of grapefruit juice was cup of apple juice was to be of pineapple juice was to be				
	be served -On Sunday, 1/2 cu	section of cantaloupe was to up of orange juice was to be				
		f fruit juice were needed to be dent for the breakfast menu				
	revealed: -On Monday, 3 oun buttered noodles, 3 slice of wheat brea pudding were to be -On Tuesday, 3 our of onion rings, 14 ou	ty's lunch menu for one week lices of meatloaf, ½ cup of ½ cup of three-bean salad, 1 d, and ½ cup of chocolate served. Inces of baked haddock, ½ cup up of spinach, ½ cup of slaw, 1 d, and 1 slice of watermelon				
		ounces of grilled ham, ½ cup es, ½ cup of buttered carrots,	:			

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Division of	of Health Service Re	egulation	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY	
CTATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMP	COMPLETED	
AND PLAN (OF CORRECTION	(FICH I ILLOW) OUT HOUSE.	A. BUILDING:				
					05/1	4/2025	
		FCL017064	B. WING				
			nnscoo, city, s	TATE, 7IP CODE			
NAME OF P	ROVIDER OR SUPPLIER		BOROUGH R				
	e ::Antianië		NC 27305				
NEW LIFE	E HORIZONS			PROVIDER'S PLAN OF	CORRECTION	(X5)	
27.47.10	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID PREFIX	ICANT CORRECTALE ACT	KON SHOULD BE	COMPLETE	
(X4) ID PREFIX	・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENCE	HE APPROPRIATE		
TAG	REGULATORY OR	ESC IDENTIFY THE THE STATE OF THE		BELIGIENC	`'1		
			C 259				
C 259	Continued From p	age 11	0 200				
	1 piece of combre	ad, and ½ cup of vanilla ice					
	croom were to be	servéd.		ne a se			
	On Thursday 1 h	peef hurrito, 1 cup of spinach					
	salad with dressin	g. ½ cup of Mexican rice, and	İ			į	
	1/ our of neaches	were to be served.					
	L On Eriday 3 Outs	ces of barbeque chicken, 72 cul	ם ן				
	of buttered neas	1/2 cup of pasta salad, I discuit		account of the contract of the			
	and 1 slice of hitte	eberry ble were to be serveu.	l				
	On Saturday, 1/3	cup of tuna salad, with lettuce					
	and tomato serve	d in pita bread. I cup of cold	1				
	spinach with yogu	irt, and sliced orange salad and	'				
1	Iomon courses W	ere to be served.		·			
i 	-On Sunday, 3 ou	inces of breaded nork natty. 1/2					
	cup of mashed po	otatoes, 1/2 cup of pickled beets,	4				
	1 dinner roll, 1/2 Ct	ip of cinnamon applesauce, and	4				
	1 slice of sweet p	otato pie were to be served. of vegetables and a minimum of	of	•			
	-A total of 4 cups	at were needed to be served for	r				
	12 ounces of the	the lunch menu for one week.	` 				
1	each resident for	the fation mond for site week					
	Review of the fac	ility's dinner menu for the week					
	revealed:			*			
	-On Monday, 3/4	cup of vegetable beef soup, a				j	
1	turkey sandwich	with cheese, 1 stalk of celery, 1				Ì	
	medium carrot, 1/	g cup of peach slices, and 2					
	cookies were to b	oe served.					
1	-On Tuccday, 3/4	cup of macaroni and cheese,	%			1	
	cup of cottage ch	eese, 1 bran muffin, 1 peach					
		mately 15 grapes were to be	ŀ				
	served.	A14P10				•	
	-On Wednesday,	3/4 cup of bean soup, a grilled					
	cheese sandwich	with tomato slices, 2 sweet	. [
i		up of apple sauce and ½ cup of					
	pudding were to						
		4 cup of minestrone soup, a					
	peanut butter and	d jelly sandwich, sliced tomato	ام			-	
		and 1 medium banana were to b	10				
	served.	d 1/4 cups of chef salad with	30 Y. (1900-000)			1	
		se, 6 crackers, and ½ cup of Je	lla (
	World Service Pegulati			1			

Division of Health Service Regulation

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If continuation sheet 12 of 35

Division of Health Service Regulation

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P. 1

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	R/SUPPLIER/CLIA :ATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. DUILDING:		(X3) DATE SURVEY COMPLETED
FCL01	7064	B. WING		05/14/2025
NAME OF PROVIDER OR SUPPLIER NEW LIFE HORIZONS	1111 YAR	DRESS, CITY, S BOROUGH I NC 27305	STATE, ZIP CODE ROAD	
(X4) ID SUMMARY STATEMENT OF DE PREFIX (EACH DEFICIENCY MUST BE PREV TAG REGULATORY OR LSC IDENTIFYING	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
C 259 Continued From page 12 with fruit cocktail were to be ser On Saturday, 1/4 cup of sloppy meat on a bun, ½ cup of sherbet well on Sunday, 3 ounces of breads buttered broccoli, ½ cup of pines slice of cake with icing were to be A total of 5 cups of vegetables were needed to be served to ear dinner menu for one week. Telephone interview with the Ad 05/14/25 at 2:49pm revealed: He thought there was enough frand protein in the facility, non-perserved if needed. He usually kept the facility "stort food. C 315 10A NCAC 13G .1002(a) Medication (a) A family care home shall enthe resident's physician or preson for verification or clarification of medications and treatments: (1) if orders for admission or readers are not clear or con (3) if multiple admission forms a admission or readmission and continue are not the same.	joe sandwich ots, 1 cup of raisin re to be served. ed fish, ½ cup of apple slaw, and 1 be served. and 3 cups of fruit ch resident for the ministrator on ruit, vegetables, erishable, to be cked up" with ation Orders on Orders sure contact with cribing practitioner orders for admission of the ed within 24 hours the facility; eplete; or are received upon	C 315	As the administ I will ensure the address are ch complete at all tin during the initial a and also readmissio the facility from a To ensure this is	eard res, damission into hospitel. done
The facility shall ensure that this clarification is documented in the record. This Rule is not met as evidence based on record reviews and in	e resident's		the PCP will be a immediately for Cla	epitication.

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Division	of Health Service Re	egulation				
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
, 1112 2701	we were to started ESP-13		A. BUILDING: _		i i	
		FCL017064	B. WING		05/1	4/2025
NAME UF I	PROVIDER OR SUPPLIER	STREET AC	DREGG, CITY, ST	ATE, ZIP CODE		
NIENAZ I SE	E HORIZONS	1111 YAR	BOROUGH RO	DAD		
MEAAFIL	E HORIZONS	MILTON,	NC 27305			· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC	NEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	COMPLETE DATE
C 315	Continued From pa	nge 13	C 315			
	physician for 1 of 3	ify orders with the prescribing sampled recidents for an , and an antipsychotic				error dagate V. Fr. Commonwealth
	The findings are:		An Livery Agent			
	revealed diagnose exacerbation, acut	t #2's FL-2 dated 04/03/25 s included acute asthma e bronchitis, r, and hypokalemia.				
		ent #2's FL-2 dated 04/03/25 for Rexulti (an antipsychotic)				
		of #2's previous FL-2 dated the medication list was ached.				
	Review of the physical Resident #2's FL-2 order for Rexulti 2	sician's orders attached to 2 dated 03/17/25 revealed an mg once daily.				
	hospital discharge	nt #2's electronically signed summary dated 04/03/25 for Rexulti 2mg once daily.				A CATALON AND A
	administration rec -There was an ent	nt #2's April 2025 medication ord (MAR) revealed: ry for Rexulti 2mg scheduled a	t			
	8:00amRexulti 2mg was 8:00am from 04/0	documented as administered a 4/25-04/30/25.	t			
	05/01/25-05/14/25 -There was an en 8:00am.	nt #2's May 2025 MAR from i revealed: try for Rexulti 2mg scheduled a documented as administered a				- The state of the

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Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY NO PLAN OF CORRECTION DENTIFICATION NUMBER A. BUILDING: _ B. WING FCL017064 05/14/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1111 YARBOROUGH ROAD **NEW LIFE HORIZONS** MILTON, NC 27305 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) U 315 | Continued From page 14 U 315 6:00am from 05/01/25-05/13/25. Observation of Resident #2's medications on hand on 05/14/25 revealed: -There was a multi-dose package that contained Rexulti 2ma. -Each bubble was dated with the date and time the medication was to be administered. -The medication was punched from 05/01/25-05/14/25. Telephone interview with a pharmacist with the facility's contracted pharmacy on 05/14/25 at 11:13am revealed: -Resident #2's rexulti was filled from a signed physician's order dated 02/06/25. -If Resident #2's FL-2 and discharge summary dated 04/03/25, were sent to the pharmacy, they would have clarified the order for -Rexulti since it was not documented on the FL-2 but was listed on the discharge summary. b. Review of Resident #2's FL-2 dated 04/03/25 revealed an order for doxycycline (an antibiotic) 100mg twice daily. Review of Resident #2's April 2025 medication administration record (MAR) from 04/03/25 to 04/30/25 revealed: -There was an entry for doxycycline 100mg, one tablet twice daily for 5 days. -There was documentation that doxycycline 100mg was administered twice daily from 04/04/25-04/08/25. -There was no other entry for doxycycline. Observation of Resident #2's medications on hand on 05/14/25 at 9:30am revealed that there was no doxycycline on hand to be administered.

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Division	of Health Service Re	egulation				
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
ANU PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A BUILDING:			
			D 188310		0514410005	
		FCL017064	B. WING		05/14	1/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		Î
AICTAL LE	E HODIZONE	1111 YARE	BOROUGH R	UAU		
MEAN FIL	E HORIZONS	MILTON, N	IC 27305			
(X4) ID		TEMENT OF DEFICIENCIES	lo lo	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETE
PREFIX TAG		MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
C 315	Continued From pa	ige 15	C 315		i	
	Telephone interviev	v with a pharmacist with the				
	facility's contracted	pharmacy on 05/14/25 at				
	11:13am revealed:	CH difference and				
		ycycline was filled from an ion for a 5-day supply.				
	-If Resident #2's FI	2 dated 04/03/25, was sent				
	to the pharmacy, th	ney would have clarified the				
		ne since there was no time				
	frame documented					
	c Review of Bosin	iont #2's FL 2 dated 04/03/25				
	revealed an order f	for prednisone (a steroid)				
	10mg daily.	·				
	D i (D i d	+ #Olin Amil 2025 modination				
	Review of Residen	t #2's April 2025 medication ord (MAR) from 04/03/25 to				
	04/30/25 revealed:					
	- I here was an enti	ry for preanisone from with the	İ			
	directions to take 4	tablets for 3 days, 3 tablets for or 3 days, and 1 tablet for 3				
	days.	or 3 days, and I tablet for 3				
	-There was docum	entation that prednisone 10mg				
	was administered	daily from 04/04/25-04/10/25.				
	-There was no oth	er entry for prednisone.				
	Observation of Re	sident #2's medications on				
1		at 9:30am revealed that there	1			
		e on hand to be administered.				
	Telephone intervie	w with a pharmacist with the				1
1	facility's contracted	d pharmacy on 05/14/25 at				
	11:13am revealed		•			
		dnisone was filled from an				
		ition for a 10-day taper. 'L-2 dated 04/03/25, was sent				
		hey would have clarified the				
		ne since there was no time				
-	frame documente	d.				
	Intonious with a m	edication aide (MA) on				
1	interview with a m	edication aide (WA) on	<u> </u>	<u> </u>		<u> </u>

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Division	Division of Health Service Regulation						
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUHTIPI F	CONSTRUCTION	(X3) DATE	1	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		CONP	LETED	
		FCL017064	B. WING		05/1	4/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
NEW LIF	E HORIZONS		BOROUGH R NC 27305	OAD		:	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
C 315	Continued From pa	ge 16	C 315				
		m and 2:14pm revealed that eviewed FL-2's and hospital es.	300				
	Interview with the Administrator on 05/14/25 at 2:49pm revealed: -The MAs did not do anything with the FL-2's and discharge summariesHe reviewed Resident #2's discharge summaryHe did not match Resident #2's medications with						
	the FL-2 or the disc		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
		v with a pharmacist with the pharmacy on 05/14/25 at					
	file at the pharmac	2 dated 04/03/25 was not on y. lered to be signed physician's					
C 330	10A NCAC 13G .10 Administration	004(a) Medication	C 330				
	(a) A family care h preparation and ad	004 Medication Administration ome shall assure that the ministration of medications,					
	by staff are in acco (1) orders by a lice	nsed prescribing practitioner					
		ed in the resident's record; and ction and the facility's policies				:	
	This Dula is not m	at as avidanced by					
	TYPE B VIOLATIO	et as evidenced by: N					
		ions, interviews, and record failed to administer					
ī	I .		1				

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STATEMEN	of Health Service Re The deficiencies OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	§	CONSTRUCTION	(X3) DATE COME	SURVEY 'LETEU
		FCL017064	B. WING	40004	05 <i>i*</i>	4/2025
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
NEW LIF	E HORIZONS	****	RBOROUGH R	COAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 330	residents (#1, #2) in treat chronic obstruction (COPD) (#1) and a nightmares and an anightmares and anightmares are acceptation, acuted pression/anxiety. Review of Residen 03/17/25 revealed: -Diagnoses include-The medication list attached. a. Review of the pill Resident #2's FL-2 order for prazosin pressure and was manage nightmare blood pressure (Bl. Review of Resident #2 was exacerbation on 0 04/03/25There was an ord hold for BP less the Review of Resider administration recurrence.	ered for 2 of 3 sampled including a medication used to including a medication used to include pulmonary disease medication used to treat allergy medication (#2). In the treat allergy medication (#2). In the treat as the treat as the treat allergy medication (#2). In the treat as the trea				

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Division	Division of Health Service Regulation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING.	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			_		
		FCL017064	B. WING		05/14/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	FATE, ZIP CODE	
NEW LIF	E HORIZONS		BOROUGH RONC 27305	OAD	
			10 21303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CURRECTIVE AUTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
C 330	Continued From pa	ge 18	C 330		:
	at 8:00pm from 03/01/25-03/30/25No BP readings were documented on the MAR. Review of Resident #2's April 2025 MAR revealed: -There was an entry for prazosin 5mg, hold if BP was less than 110/70 scheduled at 8:00pmPrazosin 5mg was documented as administered at 8:00pm from 04/04/25-04/30/25A line was drawn across the MAR for 04/01/25-04/03/25.				
					:
			- Comment		1. 2. 4.
	_	ere documented on the MAR.			
	05/01/25-05/14/25				
	was less than 110/	y for prazosin 5mg, hold if BP 70 scheduled at 8:00pm.			
	at 8:00pm from 05/	documented as administered 01/25-05/13/25. oro documented on the MAR.			
	_	ident #2's medications on			:
	hand on 05/14/25 r -There was a multi-	evealed: -dose package that contained			
	prazosin 5mg with one capsule at bed	the directions to administer time and hold for a BP of			
		dated with the date and time to be administered.			
	-The medication was 05/01/25-05/13/25.	as punched from			
	facility's contracted	w with a pharmacist with the pharmacy on 05/14/25 at			
		er dated 02/26/25 was prazosin			A manufacture shows and
	less than 110/70.	at bedtime, hold if BP was			
		ilpha blocker (Alpha blockers sels, lowering blood pressure).			:

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Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: __ 05/14/2025 B. WING _ FCL017064 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1111 YARBOROUGH ROAD **NEW LIFE HORIZONS** MILTON, NC 27305 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL BEGULATORY OR LISC IDENTIFYING INFORMATION) (X4) ID DATE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX TAG DELICIENCA) C 330 Continued From page 19 C 330 -Prazosin could cause the resident's BP to drop, and that was why it was important to take her BP before administering the medication. -Not checking Resident #2's BP before administering the prazosin, could cause the resident to experience dizziness and increase her risk of falls, especially if her BP was already low. -Resident #2 was ordered prazosin for nightmares. Interviews with Resident #2 on 05/14/25 at 10:27am and 11:49am revealed: -The medication aide (MA) had not taken her BP since she moved into the facility. -She had times she felt dizzy, like she was going to pass out. -She would lose her vision; it "got black" when she felt like she was going to pass out. -She had a fall "about one month ago" and hit her nose and mouth. -She had gotten out of bed one evening after taking her medications to get something to drink, and fell at the end of the bed. A Inamedi MA was working -She then had a second fall the same night in the hallway. -She felt dizzy when she stood up. -She did not feel dizzy every day. Observation of Resident #2 on 05/14/25 from 11:46am-12:02pm revealed: -At 11:46am, Resident #2 was lying in her bed. -At 11:49am, Resident #2 had moved to a chair, and the MA took hor BP; the reading was 81/52. -At 11:57am, Resident #2's BP was checked while standing, the reading was 92/70. -At 11:59am, Resident #2's BP was checked while lying down, the reading was 103/62. -At 12:02pm, the Licensed Health Professional Services (LHPS) nurse took the resident's BP,

Division of Health Service Regulation

5/30/2025 2:12 PM FROM: Staples TO: +19197339379 P.

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	of Health Service R	(X1) PROVIDER/SUPPLIER/CLIA	CY2) MILITIDI E	CONSTRUCTION	TACL ISY)	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION		PLETED
		FCL017064	B. WING		05	/14/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	E HORIZONS	1111 YA	RBOROUGH R	OAD		
NEW LIP	E HORIZONS	MILTON	, NC 27305			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
C 330	Continued From p	age 20	C 330	**************************************		
	and the reading w	as 107/81.				
	12:30pm revealed manually took Res and the reading w. Observation of Re 12:50pm revealed	sident #2 on 05/14/25 at she was lying on her bed, and				
	when she sat up o stated she felt dizz	n the side of the bed, she zy.				
2:14pm -He had	2:14pm revealed: -He had not check -He administered	MA on 05/14/25 at 10:31am and red Resident #2's BP. Resident #2's medications.				
	medication.	MAR to the label on the ed the order to hold the prazosion than 110/70.	n			ere e comme com (Motor e Motor e April
	10:39am and 2:20 -He checked Resi returned from the being weaned off	dent #2's BP when she hospital because she was				

Division of Health Service Regulation

bedtime.

than 110/70.

he was "just checking it."

Resident #2's BP.

at 4:16pm revealed:

there was no order on the MAR.

-It had been over a month since Resident #2 had weaned off her oxygen and he was checking

-He administered Resident #2's prazosin before

-He did not see the order to hold for a BP less

Telephone interview with a third MA on 05/14/25

-She had not taken Resident #2's BP because

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Division	of Health Service Re	egulation				
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '	CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	Lin I dale
		FCL017064	B. WING		05/1	4/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, S	TATE, ZIP CODE		
			BOROUGH R			
NEW LIF	E HORIZONS	MILTON,	NC 27305			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCHOENTHEYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
C 330	Continued From pa	nge 21	C 330			
	night. -She did not see th prazosin if her BP v					
	Interview with the A 2.49pm revealed.	Administrator on 05/14/25 at				
		dent #2's order to hold the				
	prazosin for BPs le -When he administ	ered Resident #2's				
		not pay attention to the part of e medication when the BP was	entre de la constanta de la co			
	administered witho	d the medication had been out checking her BP because omplained of being dizzy "a few				
	-He was not aware -He recalled the [n. Resident #2 compl	encouraged to "get up slowly." Resident #2 had any falls. amed] MA calling him to report iained of being dizzy and ight it was in March 2025.				TRACTIC MATERIAL AND A STORAGE
		ne interview with Resident #2's der (PCP) on 05/14/25 at cessful.				
		ne interview with the [named] 2:45pm was unsuccessful.	and a supply from the supplementary			and the state of t
	Resident #2's FL-2 order for flonase n	nysician's orders attached to 2 dated 03/17/25 revealed an asal spray (used to treat allerg prays in each nostril twice daily.				
Application in the control of the co	hospital discharge revealed:	nt #2's electronically signed summary dated 04/03/25	eries mens dans and manufacture des			
		admitted for an astrima 4/02/25 and discharged on	and the same of th			

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FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 05/14/2025 FCL017064 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1111 YARBOROUGH ROAD **NEW LIFE HORIZONS** MILTON, NC 27305 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C 330 C 330 | Continued From page 22 04/03/25. -There was an order for flonase nasal spray, two sprays in each nostril twice daily. Review of Resident #2's March 2025 MAR revealed: -There was an entry for flonase, two puffs in each nostril scheduled at 8:00am and 8:00pm. -Flonase was documented as administered at 8:00am and 8:00pm from 03/01/25-03/31/25. -There were no exceptions documented. Review of Resident #2's April 2025 MAR revealed: -There was an entry for flonase, two puffs in each nostril scheduled at 8:00am and 8:00pm. -Flonase was documented as administered at 8:00am and 8:00pm from 04/04/25-04/30/25. -A line was drawn across the MAR for 04/01/25-04/03/25 -There were no exceptions documented. Review of Resident #2's May 2025 MAR from 05/01/25-05/14/25 revealed: -There was an entry for flonase, two puffs in each nostril scheduled at 8:00am and 8:00pm. -Flonase was documented as administered at 8:00am and 8:00pm from 05/01/25-05/13/25 and on 05/14/25 at 8:00am. -There were no exceptions documented. Observation of Resident #2's medications on hand on 05/14/25 revealed: -There was a bottle of flonase that was 90% full. -The label showed the medication was dispensed on 02/17/25. Telephone interview with a pharmacist with the facility's contracted pharmacy on 05/14/25 at

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11:13am revealed:

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Division of	Health Service Re	equiation (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE S COMPL	E SURVEY MPLETED	
	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBERS	A. BUILDING: B. WING		05/1	4/2025	
		FCL017064		ATE ZIP GODE		1	
	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ALE, ZR ODDE			
			RBOROUGH RO				
NEW LIFE	HORIZONS		I, NC 27305	PROVIDER'S PLAN OF	CORRECTION	(X5) COMPLETE	
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENT REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	113-344	DATE	
TAG	Continued From page 3 of the sesident #2's flood 17/25 for a 30 to use 2 sprays in a 1f Resident #2's ordered, her aller resolved. There were no continued a firm of the sesident #2's flonase. Interview with Responding to the sesident and the sesident and the sesident #2 did not get the sesident #2 did not known and the sesident #2 did not kno	page 23 mase was dispensed on -day supply based on the order of each nostril twice daily. Iflonase was not administered a regy symptoms would not be other dispensing for Resident esident #2 on 05/14/25 at ed: ing "a little while ago". lot; she had been sneezing events all spray helped when she "go ther nasal spray every day; it ho was working. It her nasal spray when a [named]. The [named] MA on 05/14/25 at ed: ed medications by reading the hing the medications. If not have a nasal spray, we resident #2 was supposed ray twice a day. Inview with another MA on 05/14 ealed: Intered Resident #2's nasal spray en she worked, ed at the facility for approximal yeek period.	ery to 4/25 tely				
	2:49pm reveal	the Administrator on 05/14/25 a ed he was not aware Resident of been administered as ordere	#2's				

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Division	of Health Service Re	egulation				,
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		FCL017064	B. WING		05/1	14/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
NEW LIF	E HORIZONS	1111 YARI MILTON, N	BOROUGH R NC 27305	OAD		
(X4) IU PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	IU PREFIX TAG	PROVIDER'S FLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 330	Continued From pa	ge 24	C 330			
		ne interview with Resident #2's t 1:17pm was unsuccessful.				
	03/02/25 revealed: -Diagnoses include pulmonary disease disease, and panlol -There was an orde combination inhale severe COPD and one puff once daily. Review of Resident administration reco -There was an entr 200-62.5-25, inhale at 8:00am.	er for a trelegy ellipta inhaler (a rused to treat moderate to asthma) 200-62.5-25, inhale that the second statement of the second statement (MAR) revealed: by for trelegy ellipta to one puff once daily scheduled mented as administered at				
	revealed: -There was an entr 200-62.5-25, inhale at 8:00am.	one puff once daily scheduled nented as administered at				
	05/01/25-05/14/25 -There was an entr 200-62.5-25, inhale at 8:00am.	y for trelegy ellipta e one puff once daily scheduled mented as administered at				
		sident #1's medications on at 9:21am and 12:44pm				

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<u>Divisio</u> n	of Health Service Re	gulation			4	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL017064	B. WING		05/14/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
		1111 YAR	BOROUGH R	OAD		
NEW LIF	E HORIZONS	MILTON, I	NC 27305			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES I' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE COMPLETE	
C 330	Continued From pa	ge 25	C 330			
	-There was a box la dispensed on 02/27 -There were 2 inha 24 doses remaining -There was a second lipta inhaler dispensed on the dispensed on the dispensed on the dispensed on the dispensed on the dispensed on 02/27 each dispensed on 02/27 each dispensed on 02/27 each dispensing were to zeroIf Resident #1's treadministered, the dispensed on 02/27 each dispensing were dispensing were to zeroIf Resident #1's treadministered as or risk for exacerbatic a good outcome". Interview with Resident 2:04pm reveal -He used his trelegant 2:04pm reveal -He used his trelegant endication and inhaler; he would gother medicationHe did not know if he heard a click.	abeled as trelegy ellipta inhaler 7/25. Jers in the box, both showing in the inhaler out of 30. Ind box labeled as trelegy ensed on 03/26/25; the inhaler ed. Box labeled as a trelegy ellipta on 04/28/25; the inhaler had on 04/28/25; the inhaler had on 04/28/25; the inhaler had on 04/28/25; and 04/28/25 at egy ellipta inhalers were 7/25, 03/26/25, and 04/28/25; as a 30-day supply. Johalers started with a dose and time the medication was dose counter would count down elegy ellipta inhaler was not dered, the resident would be at on of his COPD, which was "not ident #1 on 05/14/25 at 9:53am led: By inhaler every day. John dered with a dose and inhale inhaler were back and inhale inhaler were back and inhale.				
	inhaler before or a					
	revealed:	A on 05/14/25 at 2:14pm				
<u></u>	-Resident #1 only	used his trelegy ellipta inhaler			<u> </u>	

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If continuation sheet 26 of 35

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Division	of Health Service Re	gulation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	! ' '	CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
V		FCL017064	B. WING		05/1	4/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
NEW LIF	E HORIZONS	1111 YARI MILTON, I	BOROUGH R NC 27305	OAD		
(X4) 1D PREFIX TAG	(EACH DEEKLENCY	TEMENT OF DEFICIENCIES MIST BE PRECEDED BY FILL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (FACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D RE	(X5) COMPLETE DATE
C 330	Continued From pa	ge 26	C 330			
	when the resident a -He did not recall th the trelegy ellipta in	e last time the resident used				
	2:20pm revealed: -He handed Reside	ond MA on 05/14/25 at int #1 his trelegy ellipta inhaler administer the medication				and a management of the manage
	when the resident t	let the resident administer the medication				
	-He did not know w 24 on the two open -He could not say w	inspensed. hy the dose counter read as ed trelegy ellipta inhalers. hat other MAs did, but he ed the trelegy ellipta when he				
	2:49pm revealed:	dministrator on 05/14/25 at				
	ellipta inhaler, he h watched him take to documented on the	ered Resident #1's trelegy anded the resident the inhaler, he medication, and then MAR. on the front indicated the				
	innaier nad been us					
	revealed a line draw	on 05/14/25 at 3:44pm wn across the MAR where a e initialed as administered was out of the facility.	3777			
	3:44pm revealed:	dministrator on 05/14/25 at the hospital for "almost" the huary 2025.				
	-He was not sure th	ne date Resident #1 went into n the resident returned to the				

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Division :	of Health Service Re	gulation		- CANATANATION	(X3) DATE S	IRVEY
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	COMPLI	
AND PLAN	OF CORRECTION	FIGURER FOULTOIR SECTION	A. BUILDING:	<u> </u>		1
			D MAINC		05/4/4	/2025
		FCL017064	B. WING		00/14	IZUZU
NAME OF E	ROVIDER OR SUPPLIER	STREET AL	ORESS, CITY, S	TATE, ZIP CODE		[
147 8416 67 1	110 // 12	1111 YAR	BOROUGH R	OAD		1
NEW LIF	E HORIZONS	MILTON,	NC 27305		·····	
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
C 330	,	age 27	C 330			
	even though the rethat was why there trelegy inhaler. Review of the trele on how to use the -Slide the cover do until you hear a "c-The counter woul-If the counter did heard the click, the medication. -Call your pharma happened. Request for Resid was made on 04/provided by the example of the counter did heard the click, the medication. -Call your pharma happened. Request for Resid was made on 04/provided by the example of the counter of the counte	own to expose the mouthpiece lick". d count down by one number, not count down when you e inhaler would not deliver the cist or healthcare provider if this lent #1's January 2025 MAR 15/25 at 3:44pm was not unvey evit date one interview with Resident #1's ider (PCP) on 05/14/25 at a resident who had a arameters to be held if her BP 0/70 and her BP had not been ninistering the medication. The ned of being dizzy, had reported	S	110000	10_ RCSX	5/28/2
	BP of 81/52 on 00 had COPD and e administered his resident at risk of This failure was of	izzy, and was noted to have a 5/14/25 (#2); and a resident wh mphysema, and was not being inhaler correctly, which put the an exacerbation of his COPD. letrimental to the health, safety e residents and constitutes a		As the administration of the pay close to this requirements the period of the period of the compliance.	entiral entraine	

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D. 30

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FCL017064	B. WING		05/1	4/2025
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NEW LIF	E HORIZONS	1111 YARI MILTON, I	BOROUGH F NC 27305	DAOP		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER (CROSS-REFERENCE))	D BE	(X5) COMPLETE DATE
C 330	Continued From pa	ge 28	C 330			
		l a plan of protection in S. 131D-34 on 05/14/25 for				
		N DATE FOR THE TYPE A1 NOT EXCEED JUNE 28,				
C 341	10A NCAC 13G .10 Administration	04 (i) Medication	C 341	Staff will rece	ive	l ./
	10A NCAC 13G .10	04 Medication Administration		Re-training ensur	ing	5/28/25
	medication adminis staff person who ad immediately followin medication to the re- resident actually taken	the administration on the tration record shall be by the iministers the medication and administration of the esident and observation of the king the medication and prior of another resident's arting is prohibited.		Re-training ensur complete compliant with all medication dispensing rules and As the administrato will continue to a the staff ensuring compliance	e.I	
	reviews, the facility immediately docum	et as evidenced by: ons, interviews, and record failed to ensure staff ented the administration of f 3 sampled residents (#1, #2,				
	The findings are:					TO A POOR MANAGEMENT
	Policy (undated) rev (MA) will ensure the was documented co	y's Medication Administration yealed the medication aide e medication administration prrectly on the medication rd (MAR) after the resident				

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Division (of Health Service Re	gulation		- CALLOTTION	(X3) DATE	SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			LETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:			ļ	
					05/4	4/2025
		FCL017064	B. WING		00/1	4/2020
	DOWNER OF SUBDIJER	STREET AC	DRESS, CITY, S	STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER		BOROUGH F			
NEW LIF	E HORIZONS		NC 27305			
			ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
(X4) ID	/EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	PREFIX	(FACH CORRECTIVE ACTION)	SHOULD BE	COMPLETE
PREFIX TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A	(PPROPINAL	
C 341	Continued From pa	age 29	C 341			
50,,	1					
	had been observed	d taking the medication, but sident being administered				
	prior to another les	sidelit being administered	-			
	medication.					
	1 Review of Resid	lent #1's current FL-2 dated				
	03/02/25 revealed		ļ			
	-Diagnoses includ	ed chronic obstructive				
	pulmonary disease	e (COPD), emphysema lung	Page 1			
	disease, and panic	obular emphysema.				
	-There was an ord	ler for divalproex (used to	- Andrews			
		orders) 500mg take two tablets	1			
	twice daily.	see in success (wond to troot				
	-There was an order for ingrezza (used to treat involuntary movement) 40mg once daily.					2
	involuntary mover	ter for melatonin (used for		man a representation of the control		
	sleep) 10mg at nig	aht				
1	-There was an ord	der for oxybutynin (used to trea	t			
	an overactive blace	lder) 5mg tale two tablets daily				
	-There was an ore	der for paliperidone (used to				
	treat schizophreni	ia) extended release (ER) 6mg				
1	twice daily.					
	-There was an or	der for paroxetine (used to trea				
	depression) 40mg	g once daily.				
	- I here was an or	der for prazosin (used to treat	***************************************			
1	There were an or	ıre) 1mg once daily. der for trelegy ellipta (a	C. A Property of the Control of the			
	combination inha	ler used to treat moderate to				
	severe COPD an	d asthma) 200-62.5-25 inhale				
	one puff into the I	ungs once daily.				
		ent #1's May 2025 medication				
	administration red					
	05/13/25-05/14/2					
	-The medication	aide (MA) failed to document th	ie			
	administration of	divalproex 500mg, melatonin				
1		5mg, paliperidone 6mg, and				
	prazosin img on	05/13/25 at 8:00pm. document the administration of	f			1
		rezza 40mg, paliperidone 6mg,		***************************************		
		, and trelegy ellipta inhaler on				
	paroxettile 40mg					

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Division	of Health Service Re	egulation				
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL017064	B, WING		05/	14/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
NEW LIFE HORIZONS 1111 YARB MILTON, N		BOROUGH RONC 27305	DAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
C 341	Continued From pa	ige 3û	C 341			!
	05/14/25 at 8:00am	1.	1			
	Refer to the intervie 8:48am.	ew with the MA on 05/14/25 at				
	Refer to the intervie 05/14/25 at 2:49pm	ew with the Administrator on n.				
	revealed diagnoses exacerbation, acute depression/anxiety -There was an orde manage mood disc					
	administration reco 05/13/25-05/14/25 -The medication ai administration of the and duloxetine 60n	revealed: de (MA) failed to document the ne resident's divalproex 500mg ng on 05/13/25 at 8:00pm. locument divalproex 500mg on				
	Refer to the intervi 8:48am.	ew with the MA on 05/14/25 at				
	Refer to the intervi 05/14/25 at 2:49pn	ew with the Administrator on n.				
	09/10/24 revealed: -Diagnoses include pulmonary disease schizophrenia, and -There was an ord	ed chronic obstructive e (COPD), edema, l arthritis. er for furosemide (used to trea				
	fluid retention) 20n	ng once daily.				

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Division	of Health Service Re	egulation			(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION TO SERVICE	A. BUILDING.		
		FCL017064	B. WING		05/14/2025
MARK OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
NAME OF E	KOMBEK ON BOLL FICH		BOROUGH R		
NEW LIF	E HORIZONS		NC 27305		
(X4) ID PREFIX TAG	CAPH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETE
C 341	Continued From pa	age 31	C 341		
C 341	-There was an ord schizophrenia) 5m - There was an ord depression) 25mg - There was an ord treat fluid retention Review of Resider administration rec 05/13/25-05/14/25 - The medication administration of 25mg on 05/13/25 - The MA failed to the resident's furn spironolactone 50 Refer to the intervent at 2:49p Interview with the revealed: -He called the resone at a time to a -He administered the MARsHe did not sign the had a family e -He did administered 05/13/25, he just -He knew he was	er for olanzapine (used to treat g once daily. er for sertraline (used to treat once daily. er for sertraline (used to treat once daily. er for spironolactone (used to n) 50mg once daily. Int #3's May 2025 medication ord (MAR) from ord (MAR) from ord (MAR) failed to document the olanzapine 5mg and sertraline of at 2:00pm. document the administration of semide 20mg and lamg on 05/14/25 at 8:00am. View with the MA on 05/14/25 at view with the Administrator on m. IMA on 05/14/25 at 8:48am sidents to the medication room administer medications. all medications and then signed the MARs on 05/13/25 because mergency. er all the medications on did not sign the MARs. supposed to sign the MARs.	d		
	medication.	nt was administered their stify" why he did not sign the medication pass.			
	Interview with the	Administrator on 05/14/25 at			Ì

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FCL017064	B. WING	97-337-1-10-94-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-	05/1	4/2025
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
NEW LIF	E HORIZONS	MILTON, I	BOROUGH F NC 27305	COAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 341	Continued From pa	ge 32	C 341		,	
C 381	medication was adr -The MA should ma correct and once th medication, the MA and there"He had seen times documented the me after administering to the MAs about th -He was concerned protocol.	ke sure the medication was e resident had taken the should document "right then when the MA had not edication pass immediately the medication and had talked	C 381			
	10A NCAC 13G .10 (b) The facility shall needed in response documented, includ appropriate health pinformed of the find. This Rule is not me Based on interview facility failed to ensure the state of t	109 Pharmaceutical Care Il assure action is taken as to the medication review and ling that the physician or professional has been ings when necessary.				
	recommendation for (Resident #3). The findings are: Review of Resident 09/1024 revealed d	#3's current FL2 dated lagnoses of edema, hol abuse, chronic obstructive				
	galth Service Population					

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P. 3

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		FCL017064	B, WING		05/1	4/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE ZIP CODE		
NAME OF 1	FROVIDER OR SOFFEIER		BOROUGH R			
NEW LIF	E HORIZONS		NC 27305			
DUALITY OF PERMIT OF DESIGNATION			ID.	PROVIDER'S PLAN OF CORRECT	:TION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	COMPLETE DATE
C 381	Continued From pa	ge 33	C 381			
C 381	Review of Resident review dated 10/10 -Resident #3 was to used to increase up body to release excepted and signormation. The following reconsultant for a Mereveals information balance, electrolyte. The form was signormation. The form had a please provider (PCP) to a recommendation. The PCP marked accepted and signormatic review of Resident #3 was to used to increase up body to release excepted and signormatic review dated 01/15 -Resident #3 was to the form was signormatic review of Resider of the form had a preject the recommon the PCP marked accepted and signormatic review of Resider review dated 04/25 -Resident #3 was used to increase upsed to increase use	t #3's pharmacy quarterly /24 revealed: aking 2 diuretics (a medication rine production, causing the cess fluid and sodium). wmmendations by the stabolic Panel (MP is a test that about the body's fluid as, and kidney function), ned by the Pharmacist. accept or reject the stabolic Panel (MP is a test that about the body's fluid as, and kidney function), ned by the Pharmacist. accept or reject the stabolic Panel (MP is a test that about the primary care accept or reject the stabolic Panel (MP is a test that about the primary care accept or reject the stabolic Panel (MP is a test that accept or reject the stabolic Panel (MP is a test that accept or the PCP to accept or endation. The recommendation as ed the form on 05/02/25. At #3's pharmacy quarterly PCP to accept or endation. The recommendation as ed the form on 05/02/25. At #3's pharmacy quarterly PCP to accept or endation. The recommendation as ed the form on 05/02/25. At #3's pharmacy quarterly PCP to accept or endation. The recommendation as ed the form on 05/02/25.				
	-An MP was not fo	cess fluid and sodium). und in the resident record.				
	please consider of in the last 6 month		1			
	-The form was sig	ned by the Pharmacist.				

Division of Health Service Regulation

STATE FORM

XW1011

If continuation sheet 34 of 35

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	NT OF DEFICIENCIES OF CORRECTION			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		FCL017064	B. WING		05/14/2025
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1111 YARBOROUGH ROAD MILTON, NC 27305					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
C 381	-The form had a pla reject the recomme -The PCP had not recommendations, to the recommendations, to the recommendations, to the recommendations, to the recommendations, to the recommendations, to the recommendations of -The pharmacist us problems noted during the would leave there administration recommendation recommendations of the PCP additional plants of the pl	ace for the PCP to accept or indation. reviewed the as evidenced by no response ation and no signature. Individually told him if there were any ing the quarterly review. Recommendations for the PCP, in in front of the medication red (MAR) book because the lat the MARs. It is a the resident's record. It is ident #3 to have labs drawn	C 381	A book was che the perpendicular perpendicular every resin the facility. have been instructed when on single perpendicular perpe	Staff Staff