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	FCL017064	A. BUILDING: _____ B. WING _____	R 08/12/2025

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

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{C 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 08/12/25.	{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: FOLLOW-UP TO A TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 3 staff sampled (A, C), who administered medications, had passed the medication aide written exam (A, C) and had completed the 5 and 10-hour medication aide training and medication administration clinical skills validation (A) before the administration of medications to residents. The findings are: Review of the facility's Medication Administration Policy revealed: -The medication aide (MA) would need to	{C 131}		

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{C 131}	Continued From page 1 successfully pass the written standardized test established by the Department of Health Service Regulation. -Only a qualified MA designated by the Administrator would administer medications. 1. Review of Staff A's, MA, personnel record revealed: -Staff A's hire date was 03/03/25. -There was no documentation Staff A completed the 15-hour MA training course. -There was no documentation Staff A was validated via the Medication Administration Clinical Skills Validation Checklist. -There was no documentation of Staff A taking and passing the MA written exam. Interview with five residents on 08/12/25 at various times between 9:00am-4:30pm revealed Staff A administered medications when she worked at the facility without any other staff members present. Review of residents' June 2025, July 2025, and August 2025 medication administration records (MARs) from 08/01/25-08/12/25 revealed that it could not be determined which initials belonged to Staff A. Telephone interview with Staff A on 08/12/25 at 4:15pm revealed: -She worked at the facility on Fridays, Saturdays, and Sundays. -She was usually the only staff member at the facility. -The Supervisor-in-Charge (SIC) came to the facility "every now and then". -The SIC came by at medication administration time 95% of the time. -When she did the medication pass, the SIC	{C 131}		

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{C 131}	Continued From page 2	{C 131}		

watched her.
-She took a MA training class a couple of years ago.
-She had not worked as a MA before this job.
-She had not had any MA training since she had been at this facility.

Interview with the SIC on 08/12/25 at 2:12pm revealed:
-He did not have to be at the facility when Staff A administered medications because he thought she was within her 60 days of MA training and could administer medications on her own.
-He told Staff A to call him if she had any questions.
-He had checked behind Staff A, and it appeared she was doing a good job.

Telephone interview with the facility's contracted RN on 08/12/25 at 2:24pm revealed:
-She provided Staff A with a video to watch to help her learn what she needed to know before doing the 15-hour MA class with the staff member.
-When she met Staff A on 05/14/25, to discuss the video and gave her a pre-test to ensure she was ready to take further MA training, the staff member failed the pre-test and admitted she had not watched the video, so she did not do the 15-hour class or the medication clinical skills checklist.
-Staff A should not be on the medication cart "at all".
-If she had completed the 15-hour MA training and been checked off on the medication clinical skills checklist, the MA could be on the cart for 60 days, but because she had not completed these, she should not be on the medication cart.

Interview with the Administrator on 08/12/25 at

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{C 131}	Continued From page 3 1:38pm revealed: -Staff A was doing training with the facility's contracted registered nurse (RN), but the RN said she could not sign off on Staff A until she passed the written medication exam. -Staff A had MA training, but the RN would not give him a copy of the the training until Staff A took and passed the medication exam. -He or the SIC was always with Staff A when she administered medications. -He thought it was okay for Staff A to administer medication if she was being supervised, so she could get practice to help her pass the MA exam. 2. Review of Staff C's, MA, personnel record revealed: -Staff C's hire date was 06/25/24. -Staff C completed the 15-hour MA training course on 07/03/24. -Staff C was validated via the Medication Administration Clinical Skills Validation Checklist on 07/03/24. -There was no documentation of Staff C taking and passing the MA written exam. Interview with five residents on 08/12/25 at various times between 9:00am-4:30pm revealed Staff C administered medications when he worked at the facility without any other staff members present. Review of residents' June 2025, July 2025, and August 2025 medication administration records (MARs) from 08/01/25-08/12/25 revealed that it could not be determined which initials belonged to Staff C. Interview with the Supervisor-in-Charge (SIC) on 08/12/25 at 2:12pm revealed: -He was at the facility when Staff C administered	{C 131}		

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{C 131}	Continued From page 4 medications. -Staff C did two [named] residents' medication during the day, but he observed the morning and evening medication passes with Staff C. -He was not going to say he had been at the facility for every medication pass, because there were times he had to miss. -There were times Staff C administered medications, and he was not at the facility. Telephone interview with the facility's contracted RN on 08/12/25 at 2:24pm revealed: -Staff C should not be on the medication cart "at all". -She told the Administrator Staff C could not be on the medication cart until he passed the written MA exam. Interview with the Administrator on 08/12/25 at 1:38pm revealed: -He or the SIC was always with Staff C when he administered medications. -He thought it was okay for Staff C to administer medication if he was being supervised, so he could get practice to help him pass the medication exam. Attempted telephone interview with Staff C on 08/12/25 at 2:22pm was unsuccessful. _____ The facility failed to ensure 2 of 3 staff who worked as a MA and administered medications to residents had completed the required MA training. Staff A had not had medication aide training, nor had she been validated to administer medications, but was administering the medications to the residents. Staff C had not taken and passed the medication aide written exam within 60 days of hire, and he continued to administer medications to all residents in the	{C 131}		

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{C 131}	Continued From page 5 facility after 60 days of hire without taking and passing the written exam. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/12/25 for this violation.	{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 interviews and record reviews, the facility failed to ensure that 2 of 3 sampled staff (A) had an examination and screening for the presence of controlled substances completed upon hire. The findings are: Review of Staff A's, medication aide (MA)/Supervisor-in-Charge (SIC) personnel record revealed: -Staff A's hire date was 03/03/25. -There was no documentation that Staff A had an examination and screening for the presence of controlled substances available.	C 148		

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C 148	Continued From page 6 Telephone interview with Staff A on 08/12/25 at 4:15pm revealed: -She had the drug screening kit but needed someone to read the results. -She thought a nurse was going to read the results at the facility a couple of weeks ago, but the nurse did not. Interview with the Administrator on 08/12/25 at 2:04pm revealed: -He could not locate Staff A's drug test screening results. -He thought Staff A had a drug screening on file. -He called Staff A, and she had the drug screening kit with her to be completed. -Staff A had tried to do the drug screening at the local health department, but was not able to. -He had contacted the facility's primary care provider (PCP), who would be able to read the results of Staff A's drug screening today, 08/12/25.	C 148		
{C 257}	10A NCAC 13G .0904(a)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (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, preparation, and serving food under sanitary conditions.	{C 257}		

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{C 257}	Continued From page 7 This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to ensure the food storage areas were clean and free from contamination, including, opened packages of deli meat, not labeled or dated, a bag of fruit that was rotten, and peppers that were rotten, and dirt, debris, and spillage on the shelves. The findings are: Observation of the refrigerator on 08/12/25 at 8:15am revealed: -There was a plastic bag that contained an open package of hot dogs. -The bag was not sealed or dated. -There was a plastic bag with an open package of bologna. -The bag was not sealed or dated. -There was an open package of bologna lying on the shelf. -The package had bologna exposed and was not dated as to when it was opened. -There was a bowl of dried cereal; it was not covered or labeled and dated. -In one of the drawers, there was a bag of an unrecognizable fruit; the fruit was covered in mold, and there was liquid at the bottom of the bag. -In a second drawer, there were multiple peppers; several had rotten spots on them.	{C 257}		

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{C 257}	Continued From page 8 -The shelves, the inside of the drawers, and the shelves on the refrigerator door had dried spillage, dirt, and debris. Interview with the Supervisor-in-Charge (SIC) on 08/12/25 at 11:44am revealed: -He cleaned the refrigerator out one day last week; he thought it was on Tuesday, 08/05/25. -The refrigerator was supposed to be cleaned once a week. -He had not had time to clean out the refrigerator this week, 08/12/25. -He had not used bologna and did not know why it was not in a plastic bag, labeled and dated. -He did not know what the bag of fruit was or who put the bag in the refrigerator. Interview with the Administrator on 08/12/25 at 3:49pm revealed: -He was not aware that there were open packages of meat that were not in containers, appropriately closed, labeled, and dated. -All food items were supposed to be kept in storage containers and labeled with contents and date. -He was not aware that the inside of the refrigerator needed to be cleaned. -All staff were responsible for cleaning the refrigerator.	{C 257}		