STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115099	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Horizons Habersham	105 Habersham Terrace Gardens Demorest, GA 30535

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and record review, the facility failed to ensure Minimum Data Set (MDS) assessments were coded accurately and physician orders were obtained for one of 28 sampled residents (R) (R9) reviewed for assessment accuracy and resident safety devices. This deficient practice had the potential to place R9 at increased risk of not receiving care and services according to her assessed needs.Findings include:Observation on 05/20/26 at 3:40 PM revealed R9 was sitting in her wheelchair. A monitoring device bracelet was clearly visible on R9's left ankle.Interview with the MDS Coordinator on 05/21/26 at 1:00 PM confirmed that R9 wore a monitoring device, the Quarterly MDS coding in Section P was incorrect. Interview with the Director of Nursing (DON) on 05/21/26 at 2:05 PM revealed that R9 currently wore a monitoring device.Review of the electronic medical record (EMR) revealed that R9 was admitted to the facility with diagnoses including dementia, mood disorder, and generalized anxiety disorder. Review of R9's Quarterly MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Further review of Section P (Restraints and Alarms) documented a code of 0, indicating no wandering or elopement alarm was in use. Review of R9's comprehensive care plan identified the following problem: wandering/risk for elopement with a start date of 10/13/25. The care plan description documented monitoring device in place. Interventions included physical redirection if the resident did not respond to verbal instructions and Certified Nursing Assistants (CNAs) ensuring the resident wore a monitoring device when at risk for elopement.

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

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review, and facility policy titled, Contracture Screen LTC-Patient Care, the facility failed to provide evidence that restorative or occupational therapy were provided for splinting and range of motion (ROM) for one out one resident (R) 34. This deficient practice had the potential to place R34 at increased risk of unmet care needs and medical complications.Findings include: Observation on 05/19/2026 at 10:15 AM revealed R34 was in bed with left hand out of the covers, contracted and no splint, roll or device. R34 stated he needed therapy on his hand.Observation on 05/20/2026 revealed R34 was resting on stretcher with left hand contracted and holding hand up to his chest.Interview with the Director of Nursing on 05/20/2026 at 6:40 AM revealed that the facility does not have a restorative program. She stated that physical therapy (PT) assessed the residents and if there was something noted by nursing staff, nursing would put in a PT order on the work list in the electronic record and would be followed through by nursing and PT.Interview with the Regional Nurse on 05/20/2026 at 4:00 PM revealed that the resident did have Occupational Therapy notes and referrals from the hospital and confirmed that this was not followed at the facility.Review of R34's clinical record revealed he had a diagnosis of craniotomy, neuro-storming, Intracranial hemorrhage. Review of the Minimum Data Set (MDS) quarterly dated 04/25/2026.Review of the admission nursing evaluation dated 01/20/2026 revealed that the resident R34 had a contracture on admission to the facility. Occupational Therapy notes from the hospital confirmed contracture to left hand with treatment needed. Review of R34's care plan revealed that no focus/goal or interventions were listed on the care plan for range of motion or contractures. On 05/20/2026 at 13:28 PM and 15:30 PM details were added to the care plan on splint for left hand and residents refusing to wear.Review of R34's Quarterly MDS dated [DATE] in section GG showed functional limitation in rom in upper extremity.Review of the facility policy titled, Contracture Screen LTC-Patient Care revealed that assessment were completed on admission to assess the residents' potential for developing a contracture. Reassessments should occur quarterly.If the resident was at risk for contractures or had contractures, appropriate interventions would be instituted. Examples of interventions included, but are not limited to:ROMPositioning scheduleSplintsNotify PT/OT if residents required a splint so they can properly assess/develop a splint schedule.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to discard expired intravenous (IV) start supplies and nasal swabs intended for use for residents in one of two medication storage. This deficient practice created the potential for expired or improperly stored supplies to be used in resident care, placing residents at risk for compromised safety, potential for adverse consequences.Findings Include:Observation on [DATE] in west hall medication storage room, revealed a bag of swabs dated with expiration date [DATE] intended for nasal or throat testing for all residents and expired peripheral IV start kits with dates from 2024. Licensed Practical Nurse (LPN) GG confirmed the expired dates on the supplies. Interview on [DATE] with the Regional Nurse revealed they do not have a policy for medication storage and supplies.Interview with Director of Nursing (DON) on [DATE] at 6:35 AM revealed that the storage room was checked by the Unit Manager. She stated that she checked the medications but had not checked the supplies. Interview with the DON on [DATE] at 8:00 AM revealed that she had started doing a daily check-off list for the unit managers to check the medication storage room and she would receive this documentation and follow up on audits.Interview on [DATE] at 2:01 PM with LPN HH revealed she had been educated by the Director of Nursing on supplies, checking expiration dates, and reordering supplies as needed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, staff and resident interviews, record review, and review of the facility policy titled, Equipment cleaning, Disinfecting and Sterilizing-Infection Prevention and Control, the facility failed to properly store and label wash basins on one hall out of four halls. This failure had the potential to put residents at risk for infection. The census was 62.Findings Include:Observation on 05/19/2026 at 9:45 AM revealed wash basins in the bathrooms in rooms 302, 307, 308 with double occupancy stacked with no name or individual bags for rooms with double occupants.Observation on 05/21/2026 at 8:30 AM revealed all washbasins had been discarded from the resident rooms on west hall. Interview on 05/21/2026 at 8:00 AM with the Director of Nursing (DON) confirmed that the wash basins in the rooms were stacked and not bagged. She stated that all the stacked and unlabeled basins had been discarded. She stated that she was setting up education for the staff. Interview on 05/21/2026 at 9:30 AM with Regional Nurse revealed that she was informed about the wash basins being stacked. The facility was in the process of starting education and new basins will be distributed to all residents.Review of the facility Policy titled, Equipment Cleaning, Disinfecting and Sterilizing-Infection Prevention and Control revealed in Section III Policy A. All reusable supplies and equipment are cleaned after use with a facility-approved antimicrobial wipe. Section F. states when clean equipment is returned, it will be appropriately marked as clean, whether with a clear plastic bag and/or other signifying feature or placed in a designated clean area.