STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115487	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Horizons Limestone	2020 Beverly Road NE Gainesville, GA 30501

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and review of the facility policy titled Oxygen Administration, Transport and Storage - Patient Care, the facility failed to ensure that oxygen (O2) therapy was administered according to physician's orders for two residents (R) (R9 and R180) of 27 residents reviewed for oxygen use. The deficient practice had the potential to increase the residents' risk of respiratory complications and adverse clinical outcomes. Findings Include: Review of the facility's undated policy titled Oxygen Administration, Transport and Storage – Patient Care, documented in section for oxygen administration A physician or advanced practice professional (APP) order is required prior to administering oxygen. The policy specifies that the order must include: a. The oxygen delivery device b. The liter flow and/or oxygen concentration (percentage). 1. Record review of the electronic medical record (EMR) revealed R9 was admitted to the facility on [DATE] and pertinent diagnoses including but not limited to atrial fibrillation, asthma, disorder of the lung, and heart failure. Review of R9's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 00, indicating severe cognitive impairment. Section GG (functional status), revealed R9 was dependent on staff for all other activities of daily living, including wheelchair mobility. Section O (special treatments and procedures) revealed no oxygen therapy or other treatments during the assessment period, as None of the above was coded. Review of R9's care plan updated 03/11/2026 revealed oxygen use was not addressed. Review of the Physician's Order for R9 included but were not limited to: Order dated 02/13/2025 for Oxygen Therapy Nasal Cannula; 2; 2; 0; Target 02 Sat: Other; as needed for SOB as needed for SOB. Initial start rate L/min: 2, max rate L/min: 2 {two liters per minute as needed for shortness of breath.} Observation made on 03/10/2026 at 11:14 AM revealed R9 was wearing her oxygen via nasal cannula (NC), and the oxygen (O2) concentrator was running at the setting of 3 liters per minute (LPM). Observation made on 03/11/2026 at 11:10 am revealed R9 was wearing her oxygen via NC and the O2 concentrator was running at the setting of 3 LPM. Observation and interview on 03/11/2026 at 11:27 am with Licensed Practical Nurse (LPN) JJ in R9's room, revealed R9's O2 concentrator remained at a setting of 3 LPM. The nurse confirmed the (continued on next page)

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	setting, exited the room to review the physician orders, and identified an order for O2 at 2 LPM. Upon returning, LPN JJ adjusted the O2 concentrator to 2 LPM. The nurse acknowledged she had not yet verified the setting during the current shift Interview on 03/11/2026 at 12:00 PM with the Director of Nursing (DON) GG revealed nursing staff are expected to check oxygen concentrator settings during medication administration and ensure the setting matches physician orders. 2. Record review of the electronic medical record (EMR) revealed R180 was admitted to the facility on [DATE] with pertinent diagnoses including but not limited to COPD (chronic obstructive pulmonary disease), OSA (obstructive sleep apnea), history of pulmonary embolus, edema. Review of R180's Minimum Data Set (MDS) annual assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 13 which indicates little to no cognitive impairment. Review of R180's care plan started 01/10/2025 revealed a problem: oxygen and interventions included but not limited to administer oxygen as ordered. Review of the Physician's Order for R180 included but were not limited to: Order dated 03/02/2026 for Nursing oxygen orders / instructions 3L {liters per minute} via nasal cannula as needed and tolerated. Observation on 03/10/2026 at 1:20 PM revealed R180 was receiving oxygen via nasal cannula at 2 liters per minute (LPM). Observation on 03/12/2026 at 10:34 AM revealed R180 was receiving oxygen via nasal cannula at 5 LPM. Observation on 03/12/2026 at 1:05 PM revealed R180 continued to receive oxygen via nasal cannula at 5 LPM. Interview and observation with RN QQ confirmed that R180's oxygen setting was at 5 LPM and the physician's order was for oxygen administration at 3 LPM. During an interview on 03/12/2026 at 2:25 PM, DON FF stated it is her expectation that nursing staff ensure oxygen is administered by physician orders and that oxygen equipment, including tubing and filters, is maintained clean and properly functioning.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and review of facility policy titled, Self-Administration of Medications, the facility failed to ensure two residents (R) (R130 and R57) could safely self-administration medications by leaving medications at the bedside unsupervised. This deficient practice had the potential to increase the risk of clinical complications. Findings include: Record review of the facility's policy titled, Self-Administration of Medications, revealed under section titled, III Policy, if a resident requests to self-administer medication (s) it is the responsibility of the interdisciplinary team (IDT) to determine that it is safe before the resident exercises that right. The policy further states that, A resident may only self-administer medications after the IDT has determined medications may be self-administered. The policy requires consideration of the resident's cognitive status, ability to follow directions, understanding of medications, and ability to ensure medications are stored safely and securely. 1. A review of the electronic health record (EHR) for R130 revealed the resident was admitted on [DATE] with diagnoses including, but not limited to, cerebral infarction, hypertension, depression, mood disorder, chronic kidney disease, and unsteadiness. A review of the Annual Minimum Data Set (MDS), dated [DATE], documented in Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) score of 15, indicating little to no cognitive impairment. Additional MDS findings revealed the resident required extensive assistance with activities of daily living (ADLs), including dependency for toileting, bathing, dressing, and personal hygiene. Record review of the care plan for R130 with a start date of 01/03/2024, documented focus areas including cognition (mild impairment), behaviors (episodes of refusing care and meals), mood related to grief and loss, and dementia-related interventions. Interventions included staff explaining care, allowing the resident to express concerns, monitoring for changes in mental status, providing simple explanations of risks and consequences, and observing for behavioral responses during care. Record review on 03/10/2026 of physician orders revealed no order for triple antibiotic ointment. A record review on 03/10/2026 of the EHR revealed no documentation that R130 was assessed for the ability to safely self-administer medications. Observations conducted on 03/10/2026 at 11:00 AM, 03/11/2026 at 10:45 AM and 03/11/2026 at 12:34 PM revealed a tube of triple antibiotic ointment on R130's bedside table. Interview and observation conducted on 03/11/2026 at 12:39 PM with Certified Nursing Assistant (CNA) AA, revealed she has worked at the facility for two years. She stated that if medication is found at the bedside, she immediately gives it to the nurse. CNA AA stated she has not encountered any residents who self-administer medications. During observation of R130's room, she stated she had not seen the triple antibiotic ointment earlier that morning and that the resident could have had it in her purse. CNA AA stated a potential negative outcome could include the resident ingesting the medication. Interview and observation conducted on 03/11/2026 at 12:44 PM with Unit Manager Registered Nurse (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(RN) BB, revealed the facility performs daily room checks due to increased items being brought in by families. RN BB stated that if medications are found at the bedside, staff remove them, notify the family, and store them for retrieval. During observation, she observed the triple antibiotic ointment on R130's bedside table. RN BB stated staff are expected to remain vigilant when entering resident rooms. She stated a potential negative outcome could include ingestion or adverse reaction if accessed by a resident. Interview conducted on 03/11/2026 at 12:51 PM with the Director of Nursing (DON) revealed the facility's expectation is that staff report medications found at the bedside, and nursing staff will remove and secure them. The DON stated residents who self-administer medications are typically assessed for their ability to do so. The DON stated potential negative outcomes could include medication interactions or overdose. Interview conducted on 03/12/2026 at 9:33 AM with the Administrator revealed the facility's protocol is to immediately remove medications found at the bedside. She stated staff conduct routine sweeps and have educated families that over-the-counter items are considered medications. She confirmed awareness of the antibiotic ointment found at Resident #130's bedside. She stated potential negative outcomes include medications getting into the wrong hands or being used improperly. 2. R57 was admitted to the facility on [DATE] with diagnoses including, but not limited to, history of cerebrovascular accident (CVA) with residual deficit, expressive aphasia, debility, abdominal distention, abdominal pain, and gastroparesis. Review of the Annual Minimum Data Set (MDS) dated [DATE] revealed the following: Section A (Identification Information) indicated the resident's preferred language is Spanish and that an interpreter is needed to communicate with a doctor or health care staff. Section B (Hearing, Speech, and Vision) indicated the resident's hearing was adequate and no hearing aid was used. The resident's speech was documented as unclear, the resident rarely made himself understood and usually understood by others. Section C (Cognitive Patterns) revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. Review of the care plan dated 03/07/2025 identified a problem related to cognitive and communication impairment, with a goal that the resident will be able to make simple decisions and communicate needs. Interventions included staff asking simple, direct questions, providing clear information, and assisting the resident with communication. The care plan indicated the resident's primary language is Spanish and that an interpreter pad may be used at times to aid communication. Documentation noted the interpreter confirmed the resident's speech in his native language is often mostly incomprehensible. Review of the physician's note dated 02/25/2025 documented, Patient is minimally verbal but gives yes and no and short responses. Review of current medications revealed orders for metoclopramide (Reglan) 10 mg four times daily and simethicone (Mylicon) chewable tablet 80 mg four times daily as needed for flatulence. On 03/10/2026 at 11:21 AM, R57 was observed in his room in a wheelchair leaving the room and entering the hallway. During the observation, two white pills with the imprint G-103 were noted in a medication cup at the resident's bedside. A photograph was taken. The resident was unable to communicate verbally with the surveyor and communicated by pointing to objects and making sounds. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Restorative Certified Nursing Assistant (CNA) DD stated the resident typically points to what he needs and staff can understand his needs through gestures. She further stated staff may also use an interpretive pad if needed. At 3:45 PM, the resident was still not in his room; however, the medications remained at the bedside. At 5:43 PM, the resident returned to his room. The surveyor pointed to the pills and asked the resident what was in the cup. The resident's response was non-comprehensible; he opened his mouth, pointed to his mouth, and repeatedly said, no, no, no. In an interview with RN EE, who was caring for the resident on 03/10/2026 at 5:44 PM, the RN stated she was not aware of medications left at R57's bedside and did not know what the white pills were. She stated medications should not be left at the bedside and further indicated the resident is not able to self-administer medications. RN EE removed the pills and identified them through an online search of the white round tablet imprint G-103, which indicated the medication was Simethicone 80 mg. RN EE then reviewed the Medication Administration Record (MAR) with the surveyor, which revealed R57 had an as-needed order for Simethicone 80 mg, with the last documented administration on 12/06/2025. The RN stated it was unlikely the medication had been sitting there since that time but did not know who left the medication at the bedside. In an interview with the Director of Nursing (DON) FF on 03/11/2026 at 10:15 AM, she stated R57 had not been assessed for self-administration of medications due to impaired cognition. She further stated her expectation is that nursing staff do not leave medications at the resident's bedside and that medications should be observed being taken by the resident. In an interview with the Licensed Practical Nurse (LPN)SS (AM Assessment Nurse) on 03/12/2026 at 1:00 PM, she stated that residents must be assessed prior to self-administering medications. She further stated that nursing staff are frequently educated that if medications are seen in residents' rooms, staff should notify the nurse and remove the medication.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility's policy titled Care Plan - LTC - Patient Care, the facility failed to develop and implement comprehensive, person-centered care plan for one resident (R) (R9) of 60 sampled residents. Specifically, the facility failed to develop and implement care plan interventions related to oxygen administration. This deficient practice had the potential to result in inadequate monitoring and improper oxygen administration, which could compromise the resident's health and safety.Findings include:Review of the undated facility policy titled Care Plan - LTC - Patient Care, documented in Section III Policy Do not leave blanks or incomplete sections. Further review revealed that Complete the . Care Plan based on . provider orders and .documents the resident's immediate problems that require nursing care interventions and will guide the delivery of nursing care.Record review of the electronic medical record (EMR) revealed R9 was admitted to the facility on [DATE] and pertinent diagnoses including but not limited to atrial fibrillation, asthma, disorder of the lung, and heart failure.Review of R9's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. Section GG: (functional status), revealed R9 was dependent on staff for all other activities of daily living, including wheelchair mobility. Section O: (special treatments and procedures), revealed oxygen therapy or other treatments were coded during the assessment period, as None of the above.Review of R9's care plan updated 03/11/2026, revealed that oxygen use was not addressed in the care plan. Review of the Physician's Order for R9 included but were not limited to:Order dated 02/13/2025 for Oxygen Therapy Nasal Cannula; 2; 2; 0; Target 02 Sat: Other; as needed for SOB as needed for SOB. Initial start rate L/min: 2, max rate L/min: 2 {liters per minute.}Observation made on 03/10/2026 at 11:14 AM revealed R9 was wearing her oxygen via nasal cannula (NC) and the oxygen (O2) concentrator was running at the setting of 3 liters per minute (LPM).Observation made on 03/11/2026 at 11:10 AM revealed R9 was wearing her oxygen via NC and the O2 concentrator was running at the setting of 3 LPM.Observation and interview on 03/11/2026 at 11:27 AM, with Licensed Practical Nurse (LPN) JJ in R9's room, revealed R9's O2 concentrator remained at a setting of 3 LPM. The nurse confirmed the setting, exited the room to review the physician orders, and identified an order for O2 at 2 LPM. Upon returning, LPN JJ adjusted the O2 concentrator to 2 LPM. The nurse acknowledged she had not yet verified the setting during the current shift.Interview on 03/12/2026 at 10:06 AM with LPN-MDS LL confirmed that oxygen use was only added to the care plan on 03/11/2026, although the oxygen order dated back to 02/13/2026. MDS LL explained that capturing oxygen use for PRN orders on the MDS is challenging and acknowledged that the care plan update regarding oxygen was missed.Interview on 03/12/2026 at 10:47 AM with the Director of Nursing (DON) GG revealed that the MDS nurse is responsible for updating the care plan promptly, ideally within 24 hours, as new orders are discussed during daily clinical meetings. The DON emphasized that timely care plan updates are critical for staff safety, as the care plan serves as a reference for nursing interventions, for example, confirming oxygen orders if a resident shows shortness of breath.

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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. Based on observation, staff interview, review of manufacturer package inserts, and facility policy titled Medication Storage, the facility failed to ensure proper medication labeling, expiration dating, discard procedures, and secure storage for one of eight medication carts. This deficient practice had the potential to place residents at risk for administration of expired, improperly labeled, or unsecured medications, which could compromise resident health and safety. Findings Include: Review of the facility's policy titled Medication Storage, dated 8/22/2023, documented All medication storage areas will inspected. to ensure that all medications are being properly and safely stored in accordance with manufacturer's instructions. IN addition, documented in section Procedures III. All expired. medications are segregated until they are removed from the organization. Outdated. medications will be kept in a designated area until they are returned to the supplier. and Item XVI. B. Medications stored throughout the center must be stored in accordance with manufacturer's instructions.to assure their integrity, stability, and effectiveness. Item H. All outdated, damaged, and discontinued medications will be disposed, returned, or held for disposal. Finally, documented under Procedure: 4. Medication Carts: a) Must be kept locked at all times unless in nurses' direct eyesight. Review of the Lantus (insulin glargine injection) package insert, page 21, item 16.2 Storage After Lantus vials have been opened (in-use), vial must be discarded 28 days after opening, whether stored refrigerated or at room temperature. 1. Observation conducted on 03/10/2026 at 11:10 AM revealed a medication cart was unlocked and positioned near the nurses' station with no nurse present or in the immediate area. The Director of Nursing (DON) was observed walking past the unlocked medication cart without addressing the issue. Interview and observation conducted on 03/10/2026 at 11:12 AM with the Director of Nursing (DON) revealed the medication cart belonged to Licensed Practical Nurse (LPN) CC. The DON stated the nurse was performing a blood sugar check at the time. The DON stated medication carts are not supposed to be left unlocked. The expectation is that any time staff step away from the cart or it is outside of their direct line of sight, the cart must be locked and the keys kept on the staff member's person. Interview conducted on 03/10/2026 at 11:16 AM with LPN CC revealed she was not aware she had left the medication cart unlocked. Interview conducted on 03/12/2026 at 9:33 AM with the Administrator revealed medication carts are not supposed to be left unlocked or unattended. The Administrator stated the expectation for staff is that medication carts are to be secured. 2. Observation and interview on 03/11/2026 at 9:55 AM of the 1-South medication cart with Licensed Practical Nurse (LPN) KK revealed the following: Expired Medication: Calcium Carbonate (antacid) tablets bottle with an expiration date of 12/2025 was present on the cart. Unlabeled/Undated Medication: One Lantus insulin pen was stored unlabeled and undated. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Incorrect Discard Date: One Lantus insulin vial had an incorrect discard date of 03/30/2026 instead of 03/29/2026 per manufacturer guidance (28 days after opening on 03/01/2026.) Interview on 03/11/2026 at 9:55 AM with LPN KK revealed that she planned to discard the expired antacid, was unsure of the owner and opening date of the unlabeled insulin pen, and corrected the insulin vial discard date to 03/29/2026, confirming the original dating error. Observation on o3/11/2026 at 10:08 AM revealed that LPN KK consulted Registered Nurse (RN) BB regarding the expired antacid and unlabeled/undated insulin pen. RN BB discarded the expired antacid, provided a new bottle for storage on the cart, and instructed LPN KK to dispose of the unlabeled insulin pen in the sharps container. Interview on 03/11/2026 at 12:03 PM with the Director of Nursing (DON) revealed that staff are responsible for checking medication carts weekly to ensure expired medications are removed and replaced as needed. The DON stated that the facility expects no expired medications to be present on the medication carts. He further explained that insulin must be labeled with the date it is opened and assigned a discard date 28 days later, and that nurses are responsible for accurately calculating and documenting this discard date. Additionally, insulin pens must be labeled by the pharmacy with the resident's name, open date, and discard date to ensure safe administration.