STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey on 06/17/21 and 06/18/21, and a desk review survey on 06/21/21 with a telephone exit on 06/22/21.	C 000		
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Facility Services, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Facility Services if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the	C 007		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 007	Continued From page 1 Division of Facility Services for review of any possible changes that may be required to the building. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the Division of Health Service Regulation (DHSR) that the resident's evacuation capabilities were different from the evacuation capabilities listed on the facility's license for 1 of 4 sampled residents (#1) who had cognitive impairments which could prevent the resident from independently evacuating the facility. The findings are: Review of the facility's current license effective 01/01/21 revealed the facility was licensed for 6 ambulatory residents. Review of the daily census revealed 4 residents resided in the facility on 06/17/21. Observation of the facility on 06/17/21 at 9:00am revealed there was one staff on duty; a medication aide/Supervisor in Charge (MA/SIC) Review of resident records revealed 1 of 4 residents had a diagnosis of dementia. Telephone interview with the Administrator on 06/21/21 at 2:17pm revealed: -He was not aware that any of the residents at the facility would have difficulties exiting the facility during a fire drill.	C 007		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 007	Continued From page 2 -He was unaware that the residents should be able to evacuate independently without verbal prompting or assistance. -He was unaware that he needed to contact construction if a resident had dementia and was unable to exit the facility without being prompted during a fire drill. Refer to a Tag C0022 10A NCAC 13G .0302(b) Design and Construction.	C 007		
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 1 of 4 sampled residents (#1) who had cognitive impairments and required verbal prompting to exit the facility during a fire drill. The findings are: Review of the facility's current license effective	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 022	Continued From page 3 01/01/21 revealed the facility was licensed for 6 ambulatory residents. Observation of the exit doors on 06/17/21 at 9:15am revealed: -The security system in place at the facility included a cow bell hanging on the inside of the front door. -There was no sounding device attached to the front door other than the cow bell. -There was no sounding device on the back door. Interview with the medication aide/Supervisor in Charge (MA/SIC) on 06/17/21 at 9:07am revealed: -The facility census was four residents. -There were not any residents at the facility who were confused and none of the residents residing in the facility had a diagnosis of dementia. -There were not any residents at the facility that required increased supervision or redirection. Based on observations, interviews, and record reviews, it was determined that 1 of 4 residents was forgetful, needed reminders, was disoriented sometimes and had a diagnosis of dementia. Review of Resident #1's current FL-2 dated 02/16/21 revealed: -Diagnoses included dementia, mood disorder due to traumatic brain injury, high blood pressure, and gastroesophageal disease. -The resident was ambulatory with a walker. -The FL-2 did not indicate the residents' orientation status. Review of Resident #1's assessment and care plan dated 02/16/21 revealed: -The resident was sometimes disoriented. -The resident was forgetful and needed	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 022	Continued From page 4	C 022		

reminders.
-The resident was ambulatory with a walker.
-The resident required extensive assistance with ambulation, dressing, grooming and toileting.

Interview with the MA/SIC on 06/17/21 at 12:00pm and 2:54pm revealed:
-Resident #1 eloped the morning of 06/09/21 and his whereabouts were unknown.
-She notified the Administrator on 06/09/21 that Resident #1 eloped.
-She realized after Resident #1 eloped that she needed to put something on the front door so she would know when it was opened.
-She hung a large cowbell on the front door to use as a door alarm on 06/09/21.
-Resident #1 did not have a diagnosis of dementia because he remembered everything.
-No residents residing at the home had a diagnosis of dementia or any memory problems.

Telephone interview with the MA/SIC on 06/22/21 at 8:09am revealed:
-She called the Administrators family member on 06/09/21 to report that Resident #1 had eloped.
-She informed the Administrators family member that there was not a door alarm on the front door.
-The Administrators family member directed her to attach a cow bell to the inside of the front door until the door alarm could be repaired.

Review of the facility fire plan policy with no date revealed:
-There should be at least four rehearsals of the fire evacuation plan each year.
-Records of the fire rehearsals should be maintained at the facility.
-The fire rehearsal records should include the date and time of rehearsal; staff members present and a brief description of what the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 022	Continued From page 5 rehearsal involved. Interview with the MA/SIC on 06/18/21 at 2:34pm revealed: -The facility performed periodic fire drills at least four times a year. -When the facility performed their last fire drill in May 2021, she rang the cow bell to alert the residents to the fire drill. -She called out "fire" to prompt residents to exit the building. -Residents knew to exit the facility and to wait in the front yard. -Residents were expected to count to ensure all residents were accounted for and safe. -For fire drills prior to May 2021, she would set off the smoke detector and yell "fire" to prompt residents to exit the building. -She was responsible for conducting the required fire drills four times a year. -She did not know that she was not supposed to prompt residents of the fire drill by yelling "fire." -All four residents were able to exit the facility safely and independently when she conducted the fire drills. Review of the facility's fire drill log revealed: -There was documentation on 10/01/20, 12/01/20, 02/01/21, 03/01/21 and 05/01/21 in which fire drills were carried out. -There was no documentation if any residents required verbal prompting or physical assistance to exit. Observation of a fire drill on 06/18/21 between 2:25pm-2:34pm revealed: -The MA/SIC removed the cow bell from the inside of the front door. -The MA/SIC rang the cow bell from the living room near the front door at 2:25pm.	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 022	Continued From page 6 -At 2:27pm, the first resident came out of his bedroom which was adjacent to the living room and exited through the front door. -At 2:27pm, a second resident came out of his bedroom which was down the hallway from the kitchen and exited through the front door. -At 2:28pm, a third resident came out of his bedroom which was down the hallway from the kitchen and exited through the front door. -At 2:30pm, the first resident that had exited the facility at the front door re-entered the facility through the front door and attempted to return to his bedroom. -The MA/SIC directed this resident to return to the front yard. -At 2:31pm, Resident #1 was observed sitting in a chair by his bed playing cards. -At 2:31pm, the MA/SIC stopped ringing the cow bell and walked to Resident #1's bedroom door adjacent to the living room and rang the cow bell. -At 2:31pm, the MA/SIC yelled "fire, fire, fire" to prompt Resident #1 at his bedroom door and continued to ring the cow bell. -At 2:32pm, Resident #1 was observed exiting his bedroom into the living room and then exited through the front door. -At 2:33pm, Resident #1 and the first resident were observed sitting on the front porch by the front door. -At 2:33pm, the MA/SIC prompted Resident #1 and his roommate to evacuate to the front yard. -It took 8 minutes for residents to exit the facility. Interview with the MA/SIC on 06/18/21 at 2:34pm revealed: -Resident #1 did not exit his room during the fire drill because he thought the cow bell sound meant the front door was being opened and closed. -Resident #1 would not respond to the cow bell	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 022	Continued From page 7 sound because he heard it when other residents entered and exited the front door and he would not associate it with a fire drill. Attempted telephone interview with Resident #1's primary care provider's (PCP) office on 06/18/21 at 8:55am was unsuccessful. Telephone interview with the Administrator on 06/21/21 at 2:43pm on 06/21/21 revealed: -He was not aware that Resident #1 had a diagnosis of dementia. -He was not aware that Resident #1 would have a difficult time exiting the building in the event of a fire. -He expected the MA/SIC to inform him if a resident had difficulties exiting the building during a fire drill. -He was concerned that Resident #1 could be injured or die during a fire if he was not able to exit the facility. _____ The facility failed to ensure the building was equipped and maintained in accordance with the facility's license capacity to allow 1 of 4 residents living in the facility who had physical and cognitive deficits to evacuate independently in case of an emergency such as a fire. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility was provided a plan of protection in accordance with G.S. 131D-34 on 06/22/21 for this violation. . CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 6, 2021.	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 069	Continued From page 8	C 069		
C 069	10A NCAC 13G .0312(g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door for resident use shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the bedroom of the person on call, the office area or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 2 of 2 exit doors were equipped with a sounding device that was audible throughout the facility when the door was opened and accessible to 1 of 4 sampled residents (#1) who had a diagnosis of dementia, was documented as disoriented and left the facility on the morning of 06/09/21 without staff knowledge. The findings are: Review of Resident #1's current FL-2 dated 02/16/21 revealed: -Diagnoses included dementia, mood disorder due to traumatic brain injury, high blood pressure, and gastroesophageal disease. -The resident was ambulatory with a walker.	C 069		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 069	Continued From page 9 -The FL-2 did not indicate the residents' orientation status. Review of Resident #1's assessment and care plan dated 02/16/21 revealed: -The resident was sometimes disoriented. -The resident was forgetful and needed reminders. -The resident was ambulatory with a walker. -The resident required extensive assistance with ambulation, dressing, grooming and toileting. Observation of the exit doors on 06/17/21 at 9:15am revealed: -The security system in place at the facility included a cow bell hanging on the inside of the front door. -There was no exit alarm on the back door. -The front door was adjacent to the living room which connected to Resident #1's bedroom. -The back door was at the end of a hallway that was adjacent to the kitchen. Interview with the medication aide/Supervisor in Charge (MA/SIC) on 06/17/21 at 9:40am revealed: -The facility had a cow bell attached to the inside of the front door for a sounding device. -There was not a sounding device on the back door of the facility. Interview with the medication aide/Supervisor in Charge (MA/SIC) on 06/17/21 at 9:07am, 12:10pm and 2:54pm revealed: -There were not any residents at the facility who were confused. -There were not any residents residing in the facility that had a diagnosis of dementia. -There were not any residents at the facility that required increased supervision or redirection.	C 069		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 069	Continued From page 10	C 069		

-She did not think Resident #1 had a diagnosis of dementia because he remembered everything.
-No residents residing at the home had a diagnosis of dementia or any memory problems.
-Resident #1 left sometime after 5:00am-6:30am on 06/09/21 without her knowledge.
-When she called residents for breakfast at 6:30am she realized that Resident #1 was not in the facility.
-She did not hear Resident #1 leave the facility because there was no sounding device on the front or back door.

Review of a police report dated 06/09/21 at 6:08am revealed:
-A deputy was dispatched to a residence on a highway at 6:12am for a suspicious person and an ambulance was needed.
-Emergency medical services (EMS) were dispatched to a residence on the highway at 6:12am.
-The resident was transported to the hospital by EMS at 6:43am.

Telephone interview with the homeowner on 06/21/21 at 3:50pm revealed:
-Resident #1 had to walk from the highway approximately 300 yards across his front yard to get to his home; his home was approximately 300 yards from the highway.
-His home was located on a busy 2 lane highway with heavy traffic.

Telephone interview with a deputy from the local sheriff's department on 06/21/21 at 4:31pm revealed:
-He was the deputy that first arrived at the scene the morning of 06/09/21.
-He went to the facility to inform staff that the resident had been located and transported to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 069	Continued From page 11	C 069		

hospital.
-He arrived at the facility at 6:45am.
-He was unable to get staff to answer the door and left.

Interview with the MA/SIC on 06/17/21 at 3:00pm revealed:
-She notified the Administrator on 06/09/21 that Resident #1 eloped.
-She realized after Resident #1 eloped that she needed to put something on the front door so she would know when it was opened.
-She hung a large cowbell on the front door to use as a door alarm on 06/09/21.

Telephone interview with the MA/SIC on 06/22/21 at 8:09am revealed:
-She called the Administrators family member on 06/09/21 to report that Resident #1 had eloped.
-She informed the Administrators family member that there was not a door alarm on the front door.
-The Administrators family member directed her to attach a cow bell to the inside of the front door until the door alarm could be repaired.

Attempted telephone interview with Resident #1's primary care provider's (PCP) office on 06/18/21 at 8:55am was unsuccessful.

Telephone interview with the Administrator on 06/21/21 at 2:43pm revealed:
-He was not aware that the door alarm was not working on the front exit.
-He was not aware that Resident #1 had a diagnosis of dementia.
-He expected the MA/SIC to inform him if a resident left the facility unsupervised.
-He was concerned that Resident #1 could be injured or die if he exited the building without staff knowledge.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 069	Continued From page 12 The facility failed to ensure 2 of 2 exit doors that were accessible to residents were equipped with a sounding device that activated when the door was opened for 1 resident with a diagnosis of dementia who left the facility without staff knowledge (Resident #1). This failure was detrimental to the health, safety and welfare of a resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/22/21 for this violation but was not accepted. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 6, 2021.	C 069		
C 100	10A NCAC 13G .0316 (e) Fire Safety And Disaster Plan 10A NCAC 13G .0316 Fire Safety And Disaster Plan (e) There shall be at least four rehearsals of the fire evacuation plan each year. Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, staff members present, and a short description of what the rehearsal involved. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that fire	C 100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 100	Continued From page 13	C 100		

evacuation plans (fire drills) included a description of what the rehearsal involved.

The findings are:

Review of the facility fire plan policy with no date revealed:
-There should be at least four rehearsals of the fire evacuation plan each year.
-Records of the fire rehearsals should be maintained at the facility.
-The fire rehearsal records should include the date and time of rehearsal; staff members present and a brief description of what the rehearsal involved.

Interview with the medication aide/Supervisor in Charge (MA/SIC) on 06/17/21 at 9:07am revealed the facility census was four residents.

Interview with the MA/SIC on 06/18/21 at 2:34pm revealed:
-The facility performed periodic fire drills at least four times a year.
-Fire drills prior to May 2021 she would set off the smoke detector and yell "fire" to prompt residents to exit the building.
-She was responsible for conducting the required fire drills annually.
-She did not know that she was not supposed to prompt residents of the fire drill by yelling "fire."
-All four residents were able to exit the facility safely and independently when she conducted the fire drills.

Review of the facility's Fire Evacuation Rehearsal Records revealed there was documentation of fire drills performed on 10/01/20, 12/01/20, 02/01/21, 03/01/21 and 05/01/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 100	Continued From page 14 Review of the facility's evacuation plan and fire drill report revealed: -There was documention a fire drill was conducted on 10/01/20 with a description of "1,7". -There was documentation fire drills were conducted on 12/01/20, 02/01/21, 03/01/21 and 05/01/21 with a description code indicating "1-7" which meant: 1. Complete evacuation of the building. 2. Rehearsal of evacuation without leaving the building. 3. Local fire department present. 4. Operation of fire extinguishers reviewed. 5. Evacuation of semi/non ambulatory residents rehearsed. 6. Orientation of new staff. 7. Orientation of new residents. Interview with the MA/SIC on 06/18/21 at 2:34pm revealed she was not able to provide a description of what each fire rehearsal involved.	C 100		
C 191	10A NCAC 13G .0601(d) Management and Other Staff 10A NCAC 13G .0601 Management and Other Staff (d) Additional staff shall be employed as needed for housekeeping and the supervision and care of the residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure sufficient staff were on duty and awake at all times to meet the supervision needs of 1 of 4 sampled residents (#1) who had a diagnosis of dementia, was	C 191		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 191	Continued From page 15 documented as disoriented and left the facility on the morning of 06/09/21 without staff knowledge. The findings are: Review of the facility's current license effective 01/01/21 revealed the facility was licensed for 6 ambulatory residents. Review of the daily census revealed 4 residents resided in the facility on 06/17/21. Observation of the facility on 06/17/21 at 9:00am revealed there was one staff on duty; a medication aide/Supervisor in Charge (MA/SIC). Review of resident records revealed 1 of 4 residents had a diagnosis of dementia. Interview with the MA/SIC on 06/17/21 at 9:07am revealed: -She was the only staff that worked at the facility. -She lived at the facility. -Her staff quarters were located down the hallway adjacent to the kitchen and included a bedroom, office, bathroom and two additional rooms. -There was an exit door at the end of the hallway that exited onto the back porch. -Residents knew that they were not allowed to exit the kitchen onto her hallway or in her staff quarters. Interview with the MA/SIC on 06/17/21 at 2:54pm revealed she did not sleep well and heard everything during the night. Interview with the MA/SIC on 06/17/21 at 9:40am revealed: -The facility had a cow bell attached to the inside of the front door for a sounding device.	C 191		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 191	Continued From page 16 -There was not a sounding device on the back door of the facility. Observation of the exit doors on 06/17/21 at 9:15am revealed: -There was a cow bell on the front door. -There was no exit alarm on the back door. -The front door was adjacent to the living room which connected to Resident #1's bedroom. -The back door was at the end of a hallway that was adjacent to the kitchen. Review of Resident #1's current FL-2 dated 02/16/21 revealed: -Diagnoses included dementia, mood disorder due to traumatic brain injury, high blood pressure, and gastroesophageal disease. -The resident was ambulatory with a walker. -The FL-2 did not indicate the residents' orientation status. Review of Resident #1's assessment and care plan dated 02/16/21 revealed: -The resident was sometimes disoriented. -The resident was forgetful and needed reminders. -The resident was ambulatory with a walker. -The resident required extensive assistance with ambulation, dressing, grooming and toileting. Review of a psychological evaluation completed for Resident #1 on 12/12/12 revealed: -Resident #1 required 24 hour supervised care. -The resident was unable to independently plan, organize, manage or provide for his ongoing daily needs. -The resident had significant deficits in self-care, learning, self-direction and capacity for independent living.	C 191		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 191	Continued From page 17 Review of a police report dated 06/09/21 at 6:08am revealed: -A deputy was dispatched to a residence on a highway at 6:12am for a suspicious person and an ambulance was needed. -Emergency medical services (EMS) were dispatched to a residence on the highway at 6:12am. -The resident was transported to the hospital by EMS at 6:43am. Interview with the MA/SIC on 06/17/21 at 9:07am revealed: -There were not any residents at the facility who were confused, there were not any residents residing in the facility that had a diagnosis of dementia and there were not any residents at the facility that required increased supervision or redirection. Interview with the MA/SIC on 06/17/21 at 2:54pm revealed she did not think Resident #1 had a diagnosis of dementia because he remembered everything and no residents residing at the home had a diagnosis of dementia or any memory problems. Based on observations, interviews, and record reviews, it was determined that 1 of 4 residents was forgetful, needed reminders, was sometimes disoriented and left the facility unsupervised on 06/09/21. Observation of Resident #1 on 06/17/21 at 9:44am revealed he was outside with another resident unsupervised. Observation of Resident #1 on 06/18/21 at 2:15pm revealed he was sitting in the front yard with another resident unsupervised.	C 191		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 191	Continued From page 18 Observation of the MA/SIC on 06/18/21 at 2:37pm revealed: -She asked a resident in the kitchen was Resident #1 still outside or had he come in the facility. -The male resident told the MA/SIC that Resident #1 was back in his bedroom. Observation of the MA/SIC on 06/18/21 at 3:23pm revealed: -She asked a resident in the kitchen if Resident #1 was outside. -The male resident informed the MA/SIC that Resident #1 was in his bedroom. -The MA/SIC was heard saying she would go and check on Resident #1 "in a bit." Telephone interview with the Administrator on 06/21/21 at 2:43pm revealed: -He was not aware that the door alarm was not working on the front exit. -He was not aware that Resident #1 had a diagnosis of dementia. -Resident #1 was "learning the building." -He expected the MA/SIC to monitor residents and ensure their safety at all times. -If a resident attempted to leave the facility, he expected the MA/SIC to hear them leaving and redirect them. -He did not have the financial means to provide 24 hour 1:1 supervision of Resident #1 and to provide an additional staff person to supervise and care for the other 3 residents at the facility. The facility failed to have sufficient staff on duty and awake at all times to meet the supervision needs of a resident with a diagnosis of dementia, was documented as disoriented and left the facility on the morning of 06/09/21 without staff	C 191		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 191	Continued From page 19 knowledge (#1). The resident required 1:1 supervision 24-hours per day, and was unable to be self-aware of his needs during any time period that supervision was not provided. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/12/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 6, 2021.	C 191		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care And Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure supervision to 1 of 3 sampled residents (#1) with a diagnosis of dementia who exited the facility without staff knowledge and walked to a home approximately half a mile from the facility with no shoes. The findings are: Review of the facility's supervision policy undated revealed:	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 20	C 243		

-Staff were always expected to know where residents were located.
-If a resident wandered from the facility the MA/SIC was expected to call 911, notify the administrator, Department of Social Services and the responsible party.
-If at least one resident is determined by a physician or it is otherwise known that resident is disoriented or a wanderer, each exit door should be equipped with a sounding device that is activated when the door is open.
-The sounding device should have sufficient volume that it can be heard from staff.
-The facility staff should provide supervision of residents based on their individual assessed needs, care plan and current symptoms.

Review of Resident #1's current FL-2 dated 02/16/21 revealed:
-Diagnoses included dementia, mood disorder due to traumatic brain injury, high blood pressure, and gastroesophageal disease.
-The resident was ambulatory with a walker.
-The FL-2 did not indicate the residents' orientation status.

Review of Resident #1's assessment and care plan dated 02/16/21 revealed:
-The resident was sometimes disoriented.
-The resident was forgetful and needed reminders.
-The resident was ambulatory with a walker.
-The resident required extensive assistance with ambulation, dressing, grooming and toileting.

Review of a psychological evaluation completed for Resident #1 on 12/12/12 revealed:
-Resident #1 required 24 hour supervised care.
-The resident was unable to independently plan, organize, manage or provide for his ongoing daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 21	C 243		

needs.
-The resident had significant deficits in self-care, learning, self-direction and capacity for independent living.

Review of a police report dated 06/09/21 at 6:08am revealed:
-A deputy was dispatched to a residence on a highway at 6:12am for a suspicious person and an ambulance was needed.
-Emergency medical services (EMS) were dispatched to a residence on the highway at 6:12am.
-The resident was transported to the hospital by EMS at 6:43am.

Review of Resident #1's discharge summary from the local hospital on 06/09/21 revealed:
-The resident was assessed for leg pain.
-Resident #1 was diagnosed with an accidental fall and a strain of his lumbar region.
-The resident was discharged from the emergency room at 9:39am.

Observation of the facility on 06/17/21 at 9:00am revealed the facility was located on a 2 lane road.

Observation of the front exit door of the facility on 06/17/21 at 9:07am revealed:
-There was no sounding device on the door.
-There was a cow bell that was attached to the inside of the front door.

Observation of the back exit door at the facility on 06/17/21 at 9:33am revealed there was no sounding device on the door.

Observation of Resident #1 on 06/17/21 at 9:44am revealed he was outside with another resident unsupervised.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 22 Observation of Resident #1 on 06/18/21 at 2:15pm revealed he was sitting in the front yard with another resident unsupervised. Observation of the MA/SIC on 06/18/21 at 2:37pm revealed: -She asked a resident in the kitchen was Resident #1 still outside or had he come in the facility. -The male resident told the MA/SIC that Resident #1 was back in his bedroom. Observation of the MA/SIC on 06/18/21 at 3:23pm revealed: -She asked a resident in the kitchen if Resident #1 was outside. -The male resident informed the MA/SIC that Resident #1 was in his bedroom. -The MA/SIC was heard saying she would go and check on Resident #1 "in a bit." Interview with Resident #1 on 06/17/21 at 9:48am outside revealed: -The Administrator put a cow bell on front exit door last week. -The MA/SIC slept at night in her room. -The morning he left the facility there was no sounding device on the front door. -He wanted to leave the facility because he did not have any money. -He could not remember where he fell on the morning, he left the facility. -His legs and feet hurt, and he wanted to get help with his pain. Interview with Resident #1's roommate on 06/17/21 at 11:00am revealed: -He shared a room with Resident #1. -The morning Resident #1 left the facility he woke	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 23	C 243		

up between 7:00am and 8:00am and realized Resident #1 was not at the home.
-The MA/SIC asked him if he knew where Resident #1 was, and he told her no.
-The MA/SIC called the Sheriff's Department.

Interview with a second resident on 06/17/21 at 11:32am revealed:
-There was no sounding device on the front or back door the morning Resident #1 left the facility.
-A cow bell was placed on the front door after Resident #1 left the facility.

Interview with a third resident on 06/17/21 at 11:24am revealed he did not know Resident #1 had left the facility the morning of 06/09/21.

Interview with the MA/SIC on 06/17/21 at 12:00pm revealed:
-Resident #1 could get away quickly, he moved "fast."
-The morning of 06/09/21 she was up at 5:00am.
-She checked on each of the residents at 5:00am and observed all 4 residents in their beds.
-Resident #1 appeared to be sleeping.
-She called the residents to come to breakfast at 6:30am.
-When she realized Resident #1 was not in the facility, she asked his roommate why he did not inform her that Resident #1 had left earlier that morning.
-She asked other residents if they had seen Resident #1.
-Sometimes the residents slipped out to smoke when she was not watching them.
-She asked other residents if Resident #1 had gone to the front porch to sneak a cigarette.
-She called 911 to inform them that Resident #1 was not in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 24 -She contacted Resident #1's primary care physician (PCP) to report the elopement and made a follow up appointment for 06/29/21. -She called Resident #1's psychiatrist's office to report the elopement. -She notified the Adult Home Specialist with the Department of Social Services of the elopement. -She attempted to call Resident #1's responsible party but was unable to reach them. -She contacted the MA/SIC at a sister facility where Resident #1 used to live to reach a family member. -The MA/SIC at the sister facility contacted Resident #1's family member to notify her of his elopement. A second interview with the MA/SIC on 06/17/21 at 2:54pm revealed: -She did not think Resident #1 had a diagnosis of dementia because "he remembered everything." -Resident #1 did not have wandering behaviors. -She did not think any of the residents at the facility that had memory problems. -Resident #1 did not have any unusual behaviors prior to his elopement on 06/09/21. -Resident #1 would go outside and smoke after eating supper. -She did not sleep well because she heard everything in the facility. A third Interview with the MA/SIC on 06/17/21 at 3:00pm revealed: -She notified the Administrator on 06/09/21 that Resident #1 eloped. -She realized after Resident #1 eloped that she needed to put something on the front door so she would know when it was opened. -She hung a large cowbell on the front door to use as a door alarm on 06/09/21.	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 25 Telephone interview with the MA/SIC on 06/22/21 at 8:09am revealed: -She called the Administrators family member on 06/09/21 to report that Resident #1 had eloped. -She informed the Administrators family member that there was not a door alarm on the front door. -The Administrators family member directed her to attach a cow bell to the inside of the front door until the door alarm could be repaired. Telephone interview with the homeowner on 06/21/21 at 3:50pm revealed: -Resident #1 had to walk from the highway approximately 300 yards across his front yard to get to his home. His home was approximately 300 yards from the highway. -His home was located on a busy 2 lane highway with heavy traffic. -Resident #1 knocked on his back door at approximately 6:10am on 06/09/21. -The resident was sitting on his walker at the homeowners back door. -The resident complained that his feet and legs hurt. -The resident had socks on but no shoes. -The resident asked the homeowner to call 911. -The resident was holding a 2 liter soda and a bag of cookies. -The resident denied being in an accident. Telephone interview with a deputy from the local sheriff's department on 06/21/21 at 4:31pm revealed: -He was the deputy that first arrived at the scene the morning of 06/09/21. -The resident was talking "nonsense" and was confused. -The residents' clothes were wet including his shirt. -The resident complained of his feet and legs	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 26	C 243		

hurting.
-The resident was wearing socks and was not wearing shoes.
-The resident was transported to a local emergency room.
-He went to the facility to inform staff that the resident was located and transported to the hospital.
-He arrived at the facility at 6:45am.
-He was unable to get staff to answer the door and left.

Telephone interview with the Administrator on 06/21/21 at 2:15pm revealed:
-He was not aware that the door alarm was not working on the front exit.
-He expected the MA/SIC to monitor residents and ensure their safety at all times.
-If a resident attempted to leave the facility, he expected the MA/SIC to hear them leaving and redirect them.
-He was concerned that Resident #1 could have been hit by a vehicle or picked up by someone.
-He expected the MA/SIC to notify the sheriff's department and then notify him if a resident eloped.

Attempted telephone interview with Resident #1's responsible party on 06/21/21 at 3:14pm was unsuccessful.

Attempted telephone interview with Resident #1's primary care physician (PCP) on 06/18/21 at 8:55am was unsuccessful.

_____

The failure of the facility to provide supervision to Resident #1 resulted in the resident exiting the facility without staff knowledge through the front door which was not alarmed; he walked along a 2 lane secondary road and then walked on a 2 lane

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 27 highway with no shoes with heavy traffic and asked a homeowner to call 911 because his legs and feet were hurting. This failure resulted in a substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/18/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 22, 2021.	C 243		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure follow up for 1 of 3 residents sampled (#1) for a podiatry appointment for complaints of bilateral foot pain, treatment of bunions and fitting for proper shoes and failed to ensure follow up appointments as ordered by his psychiatrist every 6 weeks. The findings are: Review of Resident #1's current FL-2 dated 02/16/21 revealed: -Diagnoses included dementia, mood disorder due to traumatic brain injury, high blood pressure, and gastroesophageal disease.	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 28 -The resident was ambulatory with a walker. Review of Resident #1's assessment and care plan dated 02/16/21 revealed: -The resident was sometimes disoriented. -The resident was forgetful and needed reminders. -The resident was ambulatory with a walker. -The resident required extensive assistance with ambulation, dressing, grooming and toileting. 1. Review of Resident #1's progress note from his primary care provider (PCP) dated 06/23/20 revealed: -There was a progress note dated 06/23/20 that Resident #1's was seen by his PCP. -Resident #1's PCP documented that Resident #1 complained of bilateral foot pain. -Resident #1's PCP requested the facility refer the resident to podiatry for his bunions and for proper shoes. Review of Resident #1's medical record at the facility revealed there was no documentation that he was seen by a podiatrist. Telephone interview with Resident #1's podiatrist office on 06/18/21 at 9:30am revealed: -Resident #1 was seen by the podiatrist on 11/19/20. -Resident #1 was seen for painful toenails, skin lesions, bilateral edema and itchy feet. -Resident #1 was to have a follow up visit in 3 months or sooner if needed. -There were no follow up appointments made for Resident #1 by the facility. Interview with Resident #1 on 06/17/21 at 9:48am revealed: -He was not getting enough cream for his feet;	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 29	C 246		

they were itchy and were uncomfortable.
-He had "terrible" pain in his feet and he his feet ached all the time.
-He had reported the pain in his feet to the medication aide/Supervisor in Charge (MA/SIC) several times.
-He had told the MA/SIC several times that he needed more cream to help with his itchy feet.

Observation of Resident #1's feet on 06/18/21 at 10:37am revealed:
-His left foot had a raised bunion on the top of his second toe and a blister on top of his last toe.
-The first, second and third toenails on his left foot were thick, discolored and long.
-His first and third toes were underneath his second toe.
-There was a blister on the bottom of his foot near the heel.
-His left foot was swollen.
-Both feet had dried, flakey skin on the top and around his toenails.

Interview with the MA/SIC on 06/18/21 at 10:20am revealed:
-She took Resident #1 to his PCP for help with his feet.
-Resident #1 did not take any pain medication for his feet.
-Resident #1 never complained of his feet hurting.
-She was responsible for making appointments for residents.

A second interview with the MA/SIC on 06/17/21 at 3:30pm revealed:
-Resident #1 required extensive assistance with his activities of daily living.
-She dressed the resident, buttoned his clothes and put his socks on daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 30 2. Review of Resident #1's care plan dated 02/16/21 revealed: -A referral had been made for mental health services for Resident #1. -Resident #1 was verbally abusive and had disruptive behavior. -Resident #1 was received medications for behavioral issues. Telephone interview with Resident #1's psychiatrists nurse on 06/22/21 at 2:20pm revealed: -The resident was last seen by the psychiatrist on 11/02/20. -Resident #1 had a follow up appointment with his psychiatrist scheduled for 12/21/20. -Resident #1 did not come to his appointment as his psychiatrist ordered on 12/21/21. -Resident #1 was required to have appointments with his psychiatrist every 6 weeks. Telephone interview with the Administrator on 06/21/21 at 2:20pm revealed: -He expected the MA/SIC to follow all PCP recommendations for Resident #1's referrals. -He did not know why Resident #1 was referred to the podiatrist 5 months late and then did not have a follow up visit as ordered. -There should not have been a 5 month delay in Resident #1 being referred to the podiatrist. -He expected the MA/SIC to ensure Resident #1 had his follow up visits every 6 weeks with his psychiatrist. Attempted telephone interview with Resident #1's PCP on 06/18/21 at 8:55am was unsuccessful. _____ The facility failed to follow up with a Resident's podiatrist who had ordered a follow up office visit in 3 months or sooner if needed, from an office	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 31 visit that had been delayed for 5 months which resulted in the resident complaining of "terrible" pain and constant aches in his feet as well as his feet being uncomfortable and itchy and failed to ensure follow up appointments as ordered by his psychiatrist every 6 weeks. The failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/18/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 6, 2021	C 246		
C 257	10A NCAC 13G .0904(a)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure foods being stored, prepared, and served to residents were protected from contamination related to live roaches and several dead roaches in food storage areas, opened and undated food containers in the pantry and expired food items.	C 257		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 257	Continued From page 32 The findings are: Observation of the kitchen and storage areas on 06/17/21 from 10:15am-10:45am revealed: -There was a pantry with three shelves with non-perishable food items. -Two live roaches were observed crawling on the second shelf in the pantry. -There were five dead roaches that fell out of the pantry where boxed pasta was stored on the second shelf. -There was one box of pasta that had five dead roaches at the bottom corner on the side of the box on the second shelf. -There was one macaroni and cheese boxed meal that had one dead roach on the top of the box on the second shelf. -There was a second macaroni and cheese boxed meal that had one dead roach on the side of the box that expired 03/19/21 on the second shelf. -There were two additional boxes of macaroni and cheese that were opened, unsecured and not dated on the bottom shelf. Interview with the medication aide/Supervisor in Charge (MA/SIC) on 06/17/21 at 10:35am revealed: -She was not aware that there were dead roaches on several pasta boxes. -She had not seen any live roaches in the facility. -When she saw the two live roaches in the cabinet she stated, "I get him, I spray him." -She would remove all items from the pantry and spray with a flying insect spray. -She would wait one hour after she sprayed insecticide before replacing items in the pantry. -She would deep clean the pantry as soon as possible. -She would notify the Administrator if she felt a	C 257		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 257	Continued From page 33 pest control company needed to treat the facility. -She did not realize that she had forgotten to secure two boxes of macaroni and cheese and date them. Observation of the MA/SIC on 06/17/21 at 10:37am revealed she held up an aerosol spray can with the label "Flying Insect Killer." Interview with the Administrator on 06/21/21 at 2:10pm revealed: -A pest control company sprayed the facility once a month. -He was not aware that there were dead roaches in the pantry. -He was shocked that there were 2 live roaches in the pantry. -He expected the MA/SIC to notify him if there was a problem with roaches. -He would contact the pest control company to treat the facility. Review of a pest control contract dated 06/21/21 revealed: -The service agreement for pest management was signed and dated by the Administrator and pest control company representative on 06/21/21. -The service date listed on the contract was 07/01/21. Requests for pest control invoices from the past 6 months from the Administrator on 06/21/21 at 2:10pm were not provided by survey exit on 06/22/21. _____ The facility failed to ensure foods were stored in a manner to prevent contamination as evidenced by the presence of roaches crawling in and around food being stored and served to residents. This failure was detrimental to the health, safety	C 257		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 257	Continued From page 34 and welfare of the residents, which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/12/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 6, 2021.	C 257		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to personal care and supervision, outside entrances and exits, design and construction, management and other staff, health care and nutrition and food service. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure supervision to 1 of 3 sampled residents (#1) with a diagnosis of dementia who exited the facility without staff knowledge and walked to a home approximately half a mile from the facility with no shoes. [Refer	C 912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 912	Continued From page 35 to Tag 243, 10A NCAC 13G .0901(b) Personal Care and Supervision (Type A2 Violation).] 2. Based on observations, interviews and record reviews, the facility failed to ensure 2 of 2 exit doors were equipped with a sounding device that was audible throughout the facility when the door was opened and accessible to 1 of 4 (#1) residents who had a diagnosis of dementia, was documented as disoriented and left the facility on the morning of 06/09/21 without staff knowledge. [Refer to Tag 069 10A NCAC 13G .0312(g) Outside Entrances and Exits (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 1 of 4 sampled residents (#1) who had cognitive impairments and required verbal prompting to exit the facility during a fire drill. [Refer to Tag 022 10A NCAC 13G .0302(b) Design and Construction (Type B Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to ensure sufficient staff were on duty and awake at all times to meet the supervision needs of 1 of 4 sampled residents (#1) who had a diagnosis of dementia, was documented as disoriented and left the facility on the morning of 06/09/21 without staff knowledge. [Refer to Tag 191 10A NCAC 13G .0601(d) Management and Other Staff (Type B Violation)]. 5. Based on observations, interviews, and record reviews, the facility failed to ensure follow up for 1 of 3 residents sampled (#1) for a podiatry appointment for complaints of bilateral foot pain, treatment of bunions and fitting for proper shoes and failed to ensure follow up appointments as	C 912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008030	A. BUILDING: _____ B. WING _____	R 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS	743 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 912	Continued From page 36 ordered by his psychiatrist every 6 weeks. [Refer to Tag 246 10A NCAC 13G .0902(b) Health Care (Type B Violation)]. 6. Based on observations, interviews, and record reviews, the facility failed to ensure foods being stored, prepared, and served to residents were protected from contamination related to live roaches and several dead roaches in food storage areas, opened and undated food containers in the pantry and expired food items. [Refer to Tag 257 10A NCAC 13G .0904(a)(2) Nutrition and Food Service (Type B Violation)].	C 912		