STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	,	
AND PLAN OF CORRECTIC	N	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		FCL008030	B. WING		R 06/22/202	04
NAME OF PROVIDER OR S	UPPLIER		DRESS, CITY, STA	ATE, ZIP CODE	1 00/22/202	
			LES TAYLOR F			
PATHWAYS			R, NC 27805	10/12		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	J	(X5)
PREFIX (EAC	H DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE CON	MPLETE DATE
C 000 Initial Com	000 Initial Comments		C 000			
annual and 06/18/21, a	d follow up and a desk	sure Section conducted an survey on 06/17/21 and review survey on 06/21/21 on 06/22/21.				
C 007 10A NCAC	13G .020	6 Capacity	C 007			
homes have (b) The to exceed the (c) A requested adding room modification department the Division two copies showing the force of the construction will be tied proposed (d) When designed of the construction will be tied proposed (e) The lice notify the lice and the construction of the lice and the construction of the constru	ant to G.S. Ye a capacital number is enumber is enumber is est for an ims, remodens shall be to focial in of Facility of blueprine existing and the secton, plans shall be to changes in dicensed he capacity by g of the existense or to blueprine existing into the existense of the capacity by g of the existense or the capability of the existense or of the topic of the	131D-2(a)(5), family care ity of two to six residents. of residents shall not hown on the license. Increase in capacity by leling or without any building a made to the county services and submitted to by Services, accompanied by this or floor plans. One plan building with the current use ond plan indicating the or change in use of spaces and submitted to or change in use of spaces and room. If new the license increase their the addition to or sting physical plant, the et all current fire safety the licensee's designee shall facility Services if the overall of the residents changes capability listed on the he addition of any be residing within the home.				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
			7.1. 20.125.1.101			R
		FCL008030	B. WING		06	5/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PATHWAY	'S	743 CHA	RLES TAYLOR RO	AD		
- I AIIIIIAI		AULAND	ER, NC 27805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
C 007	Continued From page	e 1	C 007			
	Division of Facility Se	ervices for review of any t may be required to the				
	reviews, the facility fa Health Service Regul resident's evacuation from the evacuation of facility's license for 1	ns, interviews, and record illed to notify the Division of ation (DHSR) that the capabilities were different capabilities listed on the of 4 sampled residents (#1) pairments which could from independently				
	The findings are:					
	1	s current license effective e facility was licensed for 6				
	Review of the daily corresided in the facility	ensus revealed 4 residents on 06/17/21.				
	revealed there was o	cility on 06/17/21 at 9:00am ne staff on duty; a ervisor in Charge (MA/SIC)				
	Review of resident re residents had a diagr					
	06/21/21 at 2:17pm re -He was not aware th	with the Administrator on evealed: at any of the residents at the ficulties exiting the facility				

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			_		R	
		FCL008030	B. WING		06/22/2021	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
PATHWAY	s		LES TAYLOR F R, NC 27805	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
C 007	Continued From page 2		C 007			
	able to evacuate inde prompting or assistan -He was unaware tha construction if a resid unable to exit the faci during a fire drill.	t he needed to contact ent had dementia and was lity without being prompted 10A NCAC 13G .0302(b)				
C 022	10A NCAC 13G .0302 Construction	2 (b) Design And	C 022			
	10A NCAC 13G .0302	2 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 a TYPE B VIOLATION	as evidenced by:				
	reviews, the facility fa evacuation capabilitie the evacuation capab current license for 1 c who had cognitive im	ns, interviews, and record iled to ensure the residents' as were in accordance with ility listed on the facility's of 4 sampled residents (#1) pairments and required xit the facility during a fire				
	The findings are:					
	Review of the facility's	s current license effective				

Division of Health Service Regulation

STATE FORM 6899 JCWY11 If continuation sheet 3 of 37

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
				_	
		FCL008030	B. WING		R 06/22/2021
		1 02000000	<u> </u>		1 00/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
PATHWAY	' Q	743 CHAR	LES TAYLOR F	ROAD	
IAIIIIIAI		AULANDE	R, NC 27805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 022	Continued From page	e 3	C 022		
	01/01/21 revealed the facility was licensed for 6 ambulatory residents.				
	9:15am revealed:	tit doors on 06/17/21 at			
	-The security system	•			
		anging on the inside of the			
	front door.	ing device attached to the			
	front door other than				
	-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 w				
		residents at the facility who			
		one of the residents residing			
	in the facility had a di	agnosis of dementia. residents at the facility that			
	_	pervision or redirection.			
		ns, interviews, and record			
	'	nined that 1 of 4 residents			
		l reminders, was disoriented			
	sometimes and had a	a diagnosis of dementia.			
	Review of Resident # 02/16/21 revealed:	1's current FL-2 dated			
		dementia, mood disorder			
	_	n injury, high blood pressure,			
	and gastroesophagea				
		nbulatory with a walker.			
	-The FL-2 did not indi orientation status.	•			
		1's assessment and care			
	plan dated 02/16/21 r -The resident was so				

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-The resident was forgetful and needed

STATE FORM 6899 JCWY11 If continuation sheet 4 of 37

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	' '		COMPLETED
			A. BUILDING: _		1
					R
		FCL008030	B. WING		06/22/2021
	DOLUBER OF SURRULES	0.70557.45	200 017/ 07/	T. T.D. 0.0.D.	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA		
PATHWAY	'S		RLES TAYLOR R	ROAD	
		AULAND	ER, NC 27805		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	MAIE
C 022	Continued From page	e 4	C 022		
	reminders.				
		bulatory with a walker.			
		d extensive assistance with			
		grooming and toileting.			
	ambulation, dressing,	grooming and tolleting.			
	Interview with the MA	/SIC on 06/17/21 at			
	12:00pm and 2:54pm				
		the morning of 06/09/21 and			
	his whereabouts were	S .			
		inistrator on 06/09/21 that			
		iiiistrator on 00/09/21 that			
	Resident #1 eloped.	:			
		esident #1 eloped that she			
		ning on the front door so she			
	would know when it w	•			
		wbell on the front door to			
	use as a door alarm o				
	-Resident #1 did not l				
		remembered everything.			
	-No residents residing				
	diagnosis of dementia	a or any memory problems.			
	T-1				
		vith the MA/SIC on 06/22/21			
	at 8:09am revealed:				
		nistrators family member on			
	•	at Resident #1 had eloped.			
		ministrators family member			
		loor alarm on the front door.			
		amily member directed her			
		the inside of the front door			
	until the door alarm o	ould be repaired.			
	Deview of the form	fire plan policy with a - d-t-			
	_	fire plan policy with no date			
	revealed:				
		east four rehearsals of the			
	fire evacuation plan e				
	-Records of the fire re				
	maintained at the faci	-			
		cords should include the			
	date and time of rehe	arsal; staff members			
	present and a brief de	escription of what the			

Division of Health Service Regulation

STATE FORM 6899 JCWY11 If continuation sheet 5 of 37

Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		FCL008030	B. WING		R
		FCL006030			06/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
	_	743 CHAF	RLES TAYLOR F	ROAD	
PATHWAY	S	AULANDI	ER, NC 27805		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
			1	DEFICIENCY)	
C 022	Continued From page	e 5	C 022		
	rehearsal involved.				
		1010 00140104 1 0 04			
		/SIC on 06/18/21 at 2:34pm			
	revealed:	al maniadia fina duilla at la aat			
	- ·	d periodic fire drills at least			
	four times a year.	formed their last fire drill in			
	• •	the cow bell to alert the			
	residents to the fire d				
		to prompt residents to exit			
	the building.	to prompt residente to exit			
	•	xit the facility and to wait in			
	the front yard.	,			
	-	ected to count to ensure all			
	residents were accou				
	-For fire drills prior to	May 2021, she would set off			
		nd yell "fire" to prompt			
	residents to exit the b	ouilding.			
	-She was responsible	e for conducting the required			
	fire drills four times a	year.			
		at she was not supposed to			
		ne fire drill by yelling "fire."			
		re able to exit the facility			
		ently when she conducted			
	the fire drills.				
	Deview of the feetited	o firo drill log rove alad			
		s fire drill log revealed:			
	-There was documen				
	which fire drills were	03/01/21 and 05/01/21 in			
		nentation if any residents			
		pting or physical assistance			
	to exit.	panig of physical assistance			
	LO OAIL.				
	Observation of a fire	drill on 06/18/21 between			
	2:25pm-2:34pm revea				
		d the cow bell from the			
	inside of the front doc				
	-The MA/SIC rang the	e cow bell from the living			
	room near the front d				

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Division of Health Service Regulation

DIVISION	of Health Service Regu	1811011 1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			B. WING		R
		FCL008030	D. WING		06/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE	
	1011211 011 001 1 21211		, ,	,	
PATHWAY	S		RLES TAYLOR R	ROAD	
		AULANDI	ER, NC 27805		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	()
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	TIALE
C 022	Continued From page	e 6	C 022		
	. •				
		esident came out of his			
		adjacent to the living room			
	and exited through the				
	-At 2:27pm, a second	resident came out of his			
	bedroom which was o	down the hallway from the			
	kitchen and exited thr	ough the front door.			
	-At 2:28pm, a third re	sident came out of his			
	bedroom which was o	down the hallway from the			
	kitchen and exited thr				
		esident that had exited the			
		or re-entered the facility			
	•	r and attempted to return to			
	his bedroom.	and attempted to retain to			
		I this resident to return to the			
	front yard.	tills resident to retain to the			
		#1 was observed sitting in a			
	chair by his bed playing	_			
	•	SIC stopped ringing the cow			
		esident #1's bedroom door			
		room and rang the cow bell.			
		SIC yelled "fire, fire, fire" to			
	· ·	t his bedroom door and			
	continued to ring the				
		#1 was observed exiting his			
		g room and then exited			
	through the front door				
		#1 and the first resident			
	were observed sitting	on the front porch by the			
	front door.				
		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 e	exit his room during the fire			
		ght the cow bell sound			
	-	was being opened and			
	closed.	og opoou uu			

Division of Health Service Regulation

-Resident #1 would not respond to the cow bell

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL008030	B. WING		06/2	2/2021
NAME OF PROVIDER C	OR SUPPLIER	STREET ADD	RESS, CITY, STA L ES TAYLOR F R, NC 27805		1 30/2	
	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
sound to entered not ass. Attempt primary at 8:55a. Telephot 06/21/2 -He was diagnosted. He was difficult fireHe expresiden a fire dresiden a fire dresid	d and exited the sociate it with a sted telephone of care provider am was unsuctione interview was a serimental to the esidents and control of the control o	ard it when other residents e front door and he would fire drill. interview with Resident #1's 's (PCP) office on 06/18/21 cessful. vith the Administrator on n 06/21/21 revealed: at Resident #1 had a	C 022	DELIGITION ()		

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
					R	
		FCL008030	B. WING			2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		743 CHARL	ES TAYLOR R	ROAD		
PATHWAY	S		R, NC 27805			
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	Ī	PROVIDER'S PLAN OF CORRECTION	J	(75)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
C 069	Continued From page 8		C 069			
C 069	10A NCAC 13G .0312(g) Outside Entrance And Exits		C 069			
	Exits (g) In homes with at I determined by a physit to be disoriented or a for resident use shall sounding device that opened. The sound is that it can be heard by of remote sounding discontrol panel for the state bedroom of the perior in a location access by the administrator to the state of the state	is activated when the door is shall be of sufficient volume y staff. If a central system evices is provided, the system shall be located in erson on call, the office area sible only to staff authorized to operate the control panel. as evidenced by: as, interviews and record ailed to ensure 2 of 2 exit with a sounding device that the facility when the door ressible to 1 of 4 sampled and a diagnosis of dementia, disoriented and left the g of 06/09/21 without staff at surrent FL-2 dated dementia, mood disorder in injury, high blood pressure,				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION (A PULL DINC)		
			A. BUILDING:			PLETED
		FCL008030	B. WING		06	R 5/ 22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	•	
		743 CHA	RLES TAYLOR RO)AD		
PATHWAY	'S		DER, NC 27805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 069	Continued From page	9	C 069			
	-The FL-2 did not indi orientation status.	icate the residents'				
	Review of Resident # plan dated 02/16/21 r	1's assessment and care evealed:				
	-The resident was so -The resident was for reminders.					
	-The resident was am	nbulatory with a walker. d extensive assistance with				
	· ·	grooming and toileting.				
	Observation of the ex	Observation of the exit doors on 06/17/21 at				
	-The security system	in place at the facility anging on the inside of the				
	front door.	-				
		arm on the back door. djacent to the living room				
		Resident #1's bedroom.				
	-The back door was a was adjacent to the k	at the end of a hallway that itchen.				
	Interview with the me Charge (MA/SIC) on revealed:	dication aide/Supervisor in 06/17/21 at 9:40am				
		w bell attached to the inside sounding device.				
		nding device on the back				
	Interview with the me Charge (MA/SIC) on	dication aide/Supervisor in				
	12:10pm and 2:54pm					
	were confused.	residents residing in the				
	facility that had a diag					
	-There were not any i	residents at the facility that upervision or redirection.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	CONSTRUCTION	(X3) DATE SURV		
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:		
		FCL008030	B. WING		R 06/22/2	2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PATHWAY	S	743 CHARI	ES TAYLOR F	ROAD		
TAIIIWAI		AULANDE	R, NC 27805			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETE DATE
C 069	Continued From page	e 10	C 069			
	-She did not think Reddementia because he -No residents residing diagnosis of dementia -Resident #1 left som on 06/09/21 without he -When she called resident #1	sident #1 had a diagnosis of a remembered everything. It is a or any memory problems. It is a problem after 5:00am-6:30am and a remembered everything. It is a or any memory problems. It is a constant after 5:00am-6:30am and constant after 5:00am-6:30am a				
	06/21/21 at 3:50pm re- Resident #1 had to wapproximately 300 ya get to his home; his h yards from the highwa	valk from the highway rds across his front yard to ome was approximately 300				
	sheriff's department of revealed: -He was the deputy the the morning of 06/09/ -He went to the facility	with a deputy from the local on 06/21/21 at 4:31pm nat first arrived at the scene 21. y to inform staff that the cated and transported to the				

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	i Health Service Regu				1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	EIED
					F	۱
		FCL008030	B. WING		1	22/2021
			_		1 55/2	
NAME OF PR	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,		
PATHWAY	S		RLES TAYLOR F	ROAD		
		AULAND	ER, NC 27805			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
IAG		,	IAG	DEFICIENCY)		
2 222			1			
C 069	Continued From page	e 11	C 069			
	hospital.					
	-He arrived at the faci	ility at 6:45am.				
		t staff to answer the door				
	and left.					
	Interview with the MA	/SIC on 06/17/21 at 3:00pm				
	revealed:					
		inistrator on 06/09/21 that				
	Resident #1 eloped.					
		esident #1 eloped that she				
	-	ning on the front door so she				
	would know when it w					
	• •	wbell on the front door to				
	use as a door alarm o	on 06/09/21.				
	Tolonhono intonvious	with the MA/SIC on 06/22/21				
	at 8:09am revealed:	vith the MA/SIC on 06/22/21				
		nistrators family member on				
		it Resident #1 had eloped.				
		ministrators family member				
		loor alarm on the front door.				
		amily member directed her				
		the inside of the front door				
	until the door alarm o					
		•				
	Attempted telephone	interview with Resident #1's				
	primary care provider	's (PCP) office on 06/18/21				
	at 8:55am was unsuc	cessful.				
	•	vith the Administrator on				
	06/21/21 at 2:43pm re					
		at the door alarm was not				
	working on the front e					
	-He was not aware th					
	diagnosis of dementia					
	· ·	/SIC to inform him if a				
	resident left the facilit	y unsupervised. nat Resident #1 could be				
	injured or die it tie ext	ited the building without staff	1			

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knowledge.

STATE FORM 6899 JCWY11 If continuation sheet 12 of 37

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NUI			(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
		FCL008030			R 06/22/2021
NAME OF D	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT		1 06/22/2021
			RLES TAYLOR R		
PATHWAY	S	AULAND	ER, NC 27805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 069	Continued From page	e 12	C 069		
C 100	were accessible to rea sounding device that was opened for 1 residementia who left the knowledge (Resident detrimental to the hear resident and constituted. The facility provided a accordance with G.S. this violation but was CORRECTION DATE VIOLATION SHALL NOT SHAL	#1). This failure was alth, safety and welfare of a ses a Type B Violation. a plan of protection in 131D-34 on 06/22/21 for not accepted. FOR THE TYPE B NOT EXCEED AUGUST 6, (e) Fire Safety And Disaster least four rehearsals of the each year. Records of aintained and copies ty department of social ne records shall include the ehearsals, staff members description of what the	C 100		
	Based on observation	ns, interviews, and record			

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DIVISION	i Health Service Regu	i auon			1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
					_	
			D WING		R	
		FCL008030	B. WING		06/2	2/2021
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
IVAIVIL OI III	TO VIDER OR OUT FIER					
PATHWAY	S		RLES TAYLOR F	ROAD		
		AULANDE	ER, NC 27805			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
			1	DEI ICIENCI)		
C 100	Continued From page	e 13	C 100			
	. •					
	evacuation plans (fire					
	description of what th	e rehearsal involved.				
	The findings are:					
	Review of the facility	fire plan policy with no date				
	revealed:					
	-There should be at le	east four rehearsals of the				
	fire evacuation plan e	each vear.				
	-Records of the fire re					
	maintained at the faci					
		cords should include the				
	date and time of rehe					
	present and a brief de	escription of what the				
	rehearsal involved.					
		dication aide/Supervisor in				
		06/17/21 at 9:07am revealed				
	the facility census wa	s four residents.				
		/SIC on 06/18/21 at 2:34pm				
	revealed:					
	-The facility performe	d periodic fire drills at least				
	four times a year.					
	-Fire drills prior to Ma	y 2021 she would set off the				
	smoke detector and y	vell "fire" to prompt residents				
	to exit the building.	• •				
	_	e for conducting the required				
	fire drills annually.					
	•	at she was not supposed to				
		ne fire drill by yelling "fire."				
		re able to exit the facility				
	•	ently when she conducted				
	the fire drills.					
	Davious of the feetites	o Fire Evenuation Deberred				
	_	s Fire Evacuation Rehearsal				
		ere was documentation of				
	fire drills performed o					
	02/01/21, 03/01/21 ar	nd 05/01/21.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		FCL008030	B. WING		06/22	2/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PATHWAY	S		.ES TAYLOR F R, NC 27805	ROAD		
()(1) ID	SLIMMADV ST.	ATEMENT OF DEFICIENCIES	Ī	PROVIDER'S PLAN OF CORRECTION	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
C 100	Continued From page	e 14	C 100			
	drill report revealed: -There was document conducted on 10/01/2 -There was document conducted on 12/01/2 05/01/21 with a describing which meant: 1. Complete evacuate 2. Rehearsal of evacuation of fire evacuation of fire evacuation of fire evacuation of semant evacuation of semant evacuation of new for expension of new for	20 with a description of "1,7". Itation fire drills were 20, 02/01/21, 03/01/21 and iption code indicating "1-7" ion of the building. Unation without leaving the ent present. Extinguishers reviewed. In information ambulatory residents of staff. It residents.				
C 191	10A NCAC 13G .060 ⁻ Staff	1(d) Management and Other	C 191			
	Staff	1 Management and Other nall be employed as needed				
	, ,	I the supervision and care of				
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	reviews, the facility fa were on duty and awa supervision needs of	ns, interviews, and record iled to ensure sufficient staff ake at all times to meet the 1 of 4 sampled residents osis of dementia, was				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R	
	FCL008030 B. WING			06/22/	2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
PATHWAY	'S		LES TAYLOR F	ROAD		
	- I	AULANDE	R, NC 27805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 191	Continued From page	e 15	C 191			
		iented and left the facility on '21 without staff knowledge.				
	The findings are:					
		s current license effective e facility was licensed for 6				
	Review of the daily coresided in the facility	ensus revealed 4 residents on 06/17/21.				
	revealed there was or	cility on 06/17/21 at 9:00am ne staff on duty; a ervisor in Charge (MA/SIC).				
	Review of resident re residents had a diagr	cords revealed 1 of 4 nosis of dementia.				
	revealed: -She was the only sta -She lived at the facili -Her staff quarters we adjacent to the kitche office, bathroom and -There was an exit do that exited onto the b -Residents knew that exit the kitchen onto h quarters.	ere located down the hallway on and included a bedroom, two additional rooms. For at the end of the hallway ack porch. They were not allowed to the hallway or in her staff				
	Interview with the MA revealed she did not everything during the					
	revealed:	/SIC on 06/17/21 at 9:40am				

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of the front door for a sounding device.

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	FCL008030		B. WING		R 06/2	2/2021
NAME OF PROV	VIDER OR SUPPLIER	STREET ADD 743 CHARL	RESS, CITY, STA		1 00/2	2/2021
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
-1 dd O 9: -1 -1 w -1 w R 0: -1 -1 oi R pl -1 -1 re -1 ai R fo -F -1 oi nd -1 le	oor of the facility. Observation of the ex: 15am revealed: There was a cow bel There was no exit ala The front door was a which connected to R The back door was a was adjacent to the ki Review of Resident # 2/16/21 revealed: Diagnoses included of ue to traumatic brain and gastroesophagea The resident was am The FL-2 did not indi- rientation status. Review of Resident # lan dated 02/16/21 re The resident was sor The resident was sor The resident was forge- minders. The resident required mbulation, dressing, Review of a psychologor Resident #1 on 12 Resident #1 required The resident was una rganize, manage or peeds.	it doors on 06/17/21 at I on the front door. arm on the back door. djacent to the living room esident #1's bedroom. t the end of a hallway that tchen. I's current FL-2 dated dementia, mood disorder injury, high blood pressure, I disease. bulatory with a walker. cate the residents' I's assessment and care evealed: metimes disoriented. getful and needed bulatory with a walker. d extensive assistance with grooming and toileting. gical evaluation completed /12/12 revealed: 24 hour supervised care. able to independently plan, provide for his ongoing daily ifficant deficits in self-care,	C 191	DEFICIENCY		

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DIVISION OF Fleatin Service Regulation							
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	EIED	
			1		,	₹	
		FCL008030	B. WING			22/2021	
		1 02000000			1 00/2	LLI LUL I	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
DATI NA(A)	•	743 CHA	RLES TAYLOR F	ROAD			
PATHWAY	8	AULAND	ER, NC 27805				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO		COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR	ROPRIATE	DATE	
				DEFICIENCY)			
C 191	Continued From page	e 17	C 191				
	Review of a police re	port dated 06/09/21 at					
	6:08am revealed:						
	-A deputy was dispate	ched to a residence on a					
	highway at 6:12am fo	or a suspicious person and					
	an ambulance was no	eeded.					
	-Emergency medical						
		ence on the highway at					
	6:12am.						
		nsported to the hospital by					
	EMS at 6:43am.						
		/SIC on 06/17/21 at 9:07am					
	revealed:						
		residents at the facility who					
		were not any residents					
		that had a diagnosis of					
		vere not any residents at the					
	redirection.	ncreased supervision or					
	redirection.						
	Interview with the MA	/SIC on 06/17/21 at 2:54pm					
		think Resident #1 had a					
		a because he remembered					
		sidents residing at the home					
		ementia or any memory					
	problems.						
	1						
	Based on observation	ns, interviews, and record					
		nined that 1 of 4 residents					
	·	reminders, was sometimes					
		ne facility unsupervised on					
	06/09/21.	- ·				 	
	•	ent #1 on 06/17/21 at					
		was outside with another					
	resident unsupervised	d.					
	-	ent #1 on 06/18/21 at					
	2:15pm revealed he v	was sitting in the front yard					

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with another resident unsupervised.

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
	FCL008030 B. WING			R 06/22/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	,
B.4.31.11.4.4.1		743 CHARL	ES TAYLOR R	OAD	
PATHWAY	S	AULANDE	R, NC 27805		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 191	Continued From page	e 18	C 191		
	facilityThe male resident to #1 was back in his be Observation of the Male 3:23pm revealed: -She asked a resident #1 was outsideThe male resident in Resident #1 was in his the MA/SIC was head check on Resident #1 Telephone interview words 12:43pm resident #1	t in the kitchen was de or had he come in the Id the MA/SIC that Resident droom. A/SIC on 06/18/21 at t in the kitchen if Resident formed the MA/SIC that s bedroom. ard saying she would go and "in a bit." with the Administrator on evealed:			
	 -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 safe -If a resident attempte				
	24 hour 1:1 supervision provide an additional	financial means to provide on of Resident #1 and to staff person to supervise 3 residents at the facility.			
	and awake at all time needs of a resident w was documented as o	ave sufficient staff on duty s to meet the supervision ith a diagnosis of dementia, disoriented and left the g of 06/09/21 without staff			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (A. BUILDING:		A. BUILDING: _		COMPLETED	
		FCL008030	B. WING		R 06/22/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PATHWAY	e	743 CHARI	ES TAYLOR F	ROAD		
TAIIIWAI		AULANDE	R, NC 27805			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE	ΓE
C 191	1 Continued From page 19		C 191			
	be self-aware of his n that supervision was failure was detrimenta	resident required 1:1 per day, and was unable to eeds during any time period not provided. The facility's al to the health, safety, and tts and constitutes a Type B				
	The facility provided a accordance with G.S. this violation.	a plan of protection in 131D-34 on 07/12/21 for				
	CORRECTION DATE VIOLATION SHALL N 2021.	FOR THE TYPE B IOT EXCEED AUGUST 6,				
C 243	10A NCAC 13G .090 Supervision	1(b) Personal Care and	C 243			
	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 TYPE A2 VIOLATION	_				
	reviews, the facility fa 1 of 3 sampled reside dementia who exited	ns, interviews, and record iled to ensure supervision to ents (#1) with a diagnosis of the facility without staffed to a home approximately acility with no shoes.				
	The findings are:					
	Review of the facility's revealed:	s supervision policy undated				

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Division of	Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	TED
					R	
		FCL008030	B. WING		06/22/	/2021
					1 00/22/	12021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE		
PATHWAY	'S	743 CHA	RLES TAYLOR R	OAD		
TAIIIIAI		AULANI	DER, NC 27805			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
IAG	REGOLATORY OF	is in the international of the	IAG	DEFICIENCY)		
C 243	Continued From page	≥ 20	C 243			
	-Staff were always ex	spected to know where				
	residents were locate					
	-If a resident wandere	ed from the facility the				
	MA/SIC was expected	d to call 911, notify the				
	administrator, Depart	ment of Social Services and				
	the responsible party					
	-If at least one reside					
		rwise known that resident is				
		lerer, each exit door should				
		ounding device that is				
	activated when the do	•				
	_	should have sufficient				
	volume that it can be					
		uld provide supervision of				
		neir individual assessed				
	needs, care plan and	current symptoms.				
	Review of Resident #	1's current FL-2 dated				
	02/16/21 revealed:	10 danoni 12 2 datod				
		dementia, mood disorder				
	_	n injury, high blood pressure,				
	and gastroesophagea					
		nbulatory with a walker.				
	-The FL-2 did not indi	icate the residents'				
	orientation status.					
		1's assessment and care				
	plan dated 02/16/21 r					
	-The resident was so					
		getiui and needed				
		abulatory with a walker				
	-					
	ambulation, aressing,	, grooming and tolleding.				
	Review of a psycholo	nical evaluation completed				
	-The resident was forgetful and needed remindersThe resident was ambulatory with a walkerThe 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

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILBING.		R	
		FCL008030	B. WING		06/22/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
PATHWAYS			RLES TAYLOR F ER, NC 27805	COAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
C 243	learning, self-direction independent living. Review of a police repletion of the formula of the front documents of the front documents. Review of a police repletion of the front documents. The resident was transparent to the local hospital on the local hospital of the facility was dispersed to the facility was a solution of the front documents.	nificant deficits in self-care, and capacity for port dated 06/09/21 at ched to a residence on a para suspicious person and peeded. Services (EMS) were ence on the highway at ensported to the hospital by chessed for leg pain. Sessed for leg pain. Sensed with an accidental lumbar region. Scharged from the charged from the charged from the charged from the charged on a 2 lane road. Sont exit door of the facility on evealed: Sensed that was attached to the force. Self exit door at the facility on evealed there was no ne door.	C 243			
	_	ent #1 on 06/17/21 at vas outside with another				

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resident unsupervised.

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Division c	<u>of Health Service Regu</u>	ılation			
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		FOI 000000	B. WING		R
		FCL008030			06/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		743 CHAF	RLES TAYLOR R	Ο Δ Π	
PATHWAY	S		ER, NC 27805		
	OLUMANA DV OT		<u>, </u>	DESCRIPTION DI ANI OF CORRECTION	.
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	<u> </u>
				DEFICIENCY)	
C 243	Otimes of From page		C 243		
C 243	Continued From page	e 22	U 243		
	Observation of Resid	ent #1 on 06/18/21 at			
		was sitting in the front yard			
	with another resident				
	Observation of the Ma	A/SIC on 06/18/21 at			
	2:37pm revealed:				
	-She asked a residen	it in the kitchen was			
		ide or had he come in the			
	facility.				
		old the MA/SIC that Resident			
	#1 was back in his be	edroom.			
	Observation of the Ma	A/SIC on 06/18/21 at			
	3:23pm revealed:				
	-She asked a residen	nt in the kitchen if Resident			
	#1 was outside.				
	-The male resident in	formed the MA/SIC that			
	Resident #1 was in hi				
	-The MA/SIC was hea	ard saying she would go and			
	check on Resident #1	1 "in a bit."			
	Interview with Reside	ent #1 on 06/17/21 at 9:48am			
	outside revealed:				
	-The Administrator pu	ut a cow bell on front exit			
	door last week.				
	-The MA/SIC slept at	_			
		the facility there was no			
	sounding device on the				
		the facility because he did			
	not have any money.				
		ber where he fell on the			
	morning, he left the fa				
	_	rt, and he wanted to get help			
	with his pain.				
	l				
	Interview with Reside				
	06/17/21 at 11:00am				
	-He shared a room w				
	-The morning Reside	nt #1 left the facility he woke			

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Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					_B
		FCI 000020	B. WING		R
		FCL008030			06/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		743 CHA	RLES TAYLOR F	ROAD	
PATHWAY	S	AULAND	ER, NC 27805		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	J (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
C 243	Continued From page	23	C 243		
	Continuou i rom page	7.20			
	•	and 8:00am and realized			
	Resident #1 was not	at the home.			
	-The MA/SIC asked h				
	Resident #1 was, and				
	-The MA/SIC called the	ne Sheriff's Department.			
		nd resident on 06/17/21 at			
	11:32am revealed:				
		ing device on the front or			
	back door the mornin	g Resident #1 left the			
	facility.				
	-	ed on the front door after			
	Resident #1 left the fa	acility.			
		resident on 06/17/21 at			
		did not know Resident #1			
	had left the facility the	e morning of 06/09/21.			
	Interview with the MA	/SIC on 06/17/21 at			
	12:00pm revealed:	/31C 011 00/17/21 at			
	•	et away quickly, he moved			
	"fast."	et away quickly, he moved			
	-The morning of 06/09	9/21 she was up at 5:00am.			
	-She checked on eac	h of the residents at 5:00am			
	and observed all 4 res	sidents in their beds.			
	-Resident #1 appeare	ed to be sleeping.			
	-She called the reside	ents to come to breakfast at			
	6:30am.				
		Resident #1 was not in the			
		roommate why he did not			
		ent #1 had left earlier that			
	morning.				
	-She asked other resi	idents if they had seen			
	Resident #1.				
	-Sometimes the resid	ents slipped out to smoke			
	when she was not wa	tching them.			
	-She asked other resi	dents if Resident #1 had			

was not in the facility.

gone to the front porch to sneak a cigarette. -She called 911 to inform them that Resident #1

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Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		FCL008030	B. WING		R 06/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
DATIMAAN	70	743 CHA	RLES TAYLOR F	ROAD	
PATHWAY	.	AULAND	ER, NC 27805		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 243	Continued From page	24	C 243		
	made a follow up app -She called Resident report the elopementShe notified the Adul Department of Social -She attempted to cal party but was unable -She contacted the M where Resident #1 us memberThe MA/SIC at the si Resident #1's family r elopement.	port the elopement and ointment for 06/29/21. #1's psychiatrist's office to the Home Specialist with the Services of the elopement. I Resident #1's responsible to reach them. A/SIC at a sister facility seed to live to reach a family			
	at 2:54pm revealed: -She did not think Redementia because "he-Resident #1 did not he-She did not think any facility that had memoral-Resident #1 did not he-Resident #1 would greating supperShe did not sleep we everything in the facil	sident #1 had a diagnosis of e remembered everything." nave wandering behaviors. of the residents at the pry problems. nave any unusual behaviors ton 06/09/21. o outside and smoke after tell because she heard ity.			
	3:00pm revealed: -She notified the Adm Resident #1 elopedShe realized after Re needed to put someth would know when it w	wbell on the front door to			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL008030	B. WING		06/2	2/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PATHWAY	9	743 CHAF	RLES TAYLOR F	ROAD		
TAIIIWAI		AULANDI	ER, NC 27805			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
C 243	Telephone interview vat 8:09am revealed: -She called the Admir 06/09/21 to report tha -She informed the Admir that there was not a direct a to attach a cow bell to until the door alarm compared to attach a second to attach a cow bell to until the door alarm compared to a to attach a second that the door alarm compared to attach a second that the door alarm compared to a to	with the MA/SIC on 06/22/21 nistrators family member on t Resident #1 had eloped. ministrators family member foor alarm on the front door. amily member directed her to the inside of the front door build be repaired. with the homeowner on evealed: walk from the highway rds across his front yard to home was approximately ghway. d on a busy 2 lane highway I on his back door at the on 06/09/21. ing on his walker at the or. ined that his feet and legs	C 243			
		ding a 2 liter soda and a				
	sheriff's department or revealed: -He was the deputy the the morning of 06/09/2The resident was talk confusedThe residents' clother shirt.	nat first arrived at the scene				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			, a boilbing.		R	
		FCL008030	B. WING		06/22/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
PATHWAYS			RLES TAYLOR F	ROAD		
			ER, NC 27805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
C 243	Continued From page	e 26	C 243			
	hurtingThe resident was we wearing shoesThe resident was tra emergency roomHe went to the facilit resident was located hospitalHe arrived at the facHe was unable to ge and left. Telephone interview wo 06/21/21 at 2:15pm relevant working on the front elevant working on the front elevant elevant expected the MA and ensure their safe elf a resident attempte expected the MA/SIC redirect themHe was concerned the expected the MA department and then eloped. Attempted telephone	raring socks and was not Insported to a local If y to inform staff that the and transported to the solution is staff to answer the door with the Administrator on evealed: If y to inform staff that the door staff to answer the door door alarm was not exit. If y is a local was not exit.				
	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 faci Resident #1 resulted facility without staff kr door which was not a	lity to provide supervision to in the resident exiting the nowledge through the front larmed; he walked along a 2 and then walked on a 2 lane				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION (X3) DATE COMP		SURVEY PLETED
		FCL008030	B. WING		06	R 5/ 22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
PATHWAY	'S		ARLES TAYLOR RO DER, NC 27805	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 243	asked a homeowner and feet were hurting substantial risk of seconstitutes a Type A The facility provided accordance with G.S this violation. CORRECTION DAT VIOLATION SHALL 2021.	es with heavy traffic and to call 911 because his legs g. This failure resulted in a crious physical harm and 2 Violation. a plan of protection in 6. 131D-34 on 06/18/21 for E FOR THE TYPE A2 NOT EXCEED JULY 22,	C 243			
C 246	to meet the routine a of residents. This Rule is not met TYPE B VIOLATION Based on observation reviews, the facility for 3 residents sampl appointment for combination treatment of bunions and failed to ensure ordered by his psychological The findings are: Review of Resident 102/16/21 revealed: -Diagnoses included	D2 Health Care assure referral and follow-up and acute health care needs t as evidenced by:	C 246			

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DIVISION	n nealth Service Negu	ialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			_		_	
			D MINO		R	
		FCL008030	B. WING	-	06/22/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
TO WILL OF TH	NOVIBER OR GOLFELIK			, and the second		
PATHWAY	S		LES TAYLOR F	ROAD		
		AULANDE	R, NC 27805			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IAIE DAIE	-
				22.10.2.10.1		
C 246	Continued From page	e 28	C 246			
	. •					
	-The resident was am	bulatory with a walker.				
	Review of Resident #	1's assessment and care				
	plan dated 02/16/21 r	evealed:				
	-The resident was sor	metimes disoriented.				
	-The resident was for	getful and needed				
	reminders.					
	-The resident was am	ibulatory with a walker.				
		d extensive assistance with				
		grooming and toileting.				
	ag,	g. coming and tonomig.				
	1 Review of Residen	t #1's progress note from his				
		(PCP) dated 06/23/20				
	revealed:	(1 C1) dated 00/25/20				
		s note dated 06/23/20 that				
	Resident #1's was se	•				
		ocumented that Resident #1				
	complained of bilatera					
		equested the facility refer				
	•	ry for his bunions and for				
	proper shoes.					
		1's medical record at the				
	facility revealed there	was no documentation that				
	he was seen by a poo	diatrist.				
	Telephone interview v	vith Resident #1's podiatrist				
	office on 06/18/21 at 9	9:30am revealed:				
	-Resident #1 was see	en by the podiatrist on				
	11/19/20.					
	-Resident #1 was see	en for painful toenails, skin				
	lesions, bilateral eder					
		nave a follow up visit in 3				
	months or sooner if n	•				
		up appointments made for				
	Resident #1 by the fa					
	Toolaont #1 by the la					
	Interview with Reside	nt #1 on 06/17/21 at 9:48am				
	revealed.	III # 1 011 00/11/21 at 9.40a111				

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-He was not getting enough cream for his feet;

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DIVISION	i Health Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	Y
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		
			1			
		FOI 000000	B. WING		R	
		FCL008030	1 2. 7/11/0		06/22/20	2 1
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		743 CHAE	LES TAYLOR F	ROAD		
PATHWAY	S		R, NC 27805	COAD		
		AULANDE	- R, NC 27605			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) MPLETE
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
IAG			IAG	DEFICIENCY)		
			+			
C 246	Continued From page	e 29	C 246			
	thou were itahy and w	voro una emfortable				
	they were itchy and w					
	-	n in his feet and he his feet				
	ached all the time.	and the late for all 4 all a				
	-He had reported the					
	-	ervisor in Charge (MA/SIC)				
	several times.					
		SIC several times that he				
	needed more cream t	to help with his itchy feet.				
	-	ent #1's feet on 06/18/21 at				
	10:37am revealed:					
	-His left foot had a rai	ised bunion on the top of his				
	second toe and a blis	ter on top of his last toe.				
	-The first, second and	d third toenails on his left				
	foot were thick, disco	lored and long.				
	-His first and third toe	es were underneath his				
	second toe.					
	-There was a blister of	on the bottom of his foot				
	near the heel.					
	-His left foot was swo	llen.				
	-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.	- · · · · · · · · · · · · · · · · · · ·				
		take any pain medication for				
	his feet.	, [
		omplained of his feet hurting.				
		e for making appointments				
	for residents.					
	A second interview wi	ith the MA/SIC on 06/17/21				
	at 3:30pm revealed:	10 10 10 10 01 00 11/21				
		d extensive assistance with				
	his activities of daily li					
		ident, buttoned his clothes				
	and put his socks on	daliy.				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		
		FCL008030	B. WING		R 06/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
PATHWAY	S		LES TAYLOR R	COAD	
			R, NC 27805		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 246	6 Continued From page 30		C 246		
C 240	2. Review of Residen 02/16/21 revealed: -A referral had been reservices for Resident -Resident #1 was ver disruptive behaviorResident #1 was recebehavioral issues. Telephone interview was psychiatrists nurse or revealed: -The resident was lass 11/02/20Resident #1 had a for psychiatrist scheduled -Resident #1 did not on his psychiatrist ordered -Resident #1 was required with his psychiatrist endicated the MA recommendations for the did not know why the podiatrist 5 month a follow up visit as ordered -The expected the MA resident #1 being reformed the MA resident #1 being	t #1's care plan dated made for mental health #1. bally abusive and had eived medications for with Resident #1's n 06/22/21 at 2:20pm It seen by the psychiatrist on for 12/21/20. Come to his appointment with his d for 12/21/21. uired to have appointments very 6 weeks. with the Administrator on evealed: //SIC to follow all PCP Resident #1's referrals. // Resident #1 was referred to his late and then did not have dered. // We been a 5 month delay in ferred to the podiatrist. //SIC to ensure Resident #1 s every 6 weeks with his interview with Resident #1's	C 240		
	podiatrist who had or	ollow up with a Resident's dered a follow up office visit r if needed, from an office			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			71. 201221110		R
		FCL008030	B. WING		06/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
PATHWAY	'S		LES TAYLOR R R, NC 27805	OAD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 246	resulted in the resider pain and constant act feet being uncomfortate ensure follow up appropriate psychiatrist every 6 with detrimental to the heat the residents and conformal formal facility provided a accordance with G.S. this violation. THE CORRECTION INVIOLATION SHALL IN 2021	layed for 5 months which not complaining of "terrible" nes in his feet as well as his able and itchy and failed to bintments as ordered by his reeks. The failure was alth, safety and welfare of astitutes a Type B Violation. The plan of protection in 131D-34 on 06/18/21 for DATE FOR THE TYPE B HOT EXCEED AUGUST 6,	C 246		
C 257	Service 10A NCAC 13G .0904 (a) Food Procurement Homes: (2) All food and bever prepared or served by protected from contart. This Rule is not met TYPE B VIOLATION. Based on observation reviews, the facility fastored, prepared, and protected from contart roaches and several estorage areas, opene	nination. as evidenced by: as, interviews, and record iled to ensure foods being I served to residents were mination related to live dead roaches in food	C 257		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	A. BUILDING:		
		FCL008030	B. WING		R 06/22/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	,	
		743 CHARI	ES TAYLOR F	ROAD		
PATHWAY	S		R, NC 27805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
C 257	7 Continued From page 32		C 257			
		7.02				
	The findings are:					
	O6/17/21 from 10:15a -There was a pantry of non-perishable food if a pantry where boxed pantry where was one boxed pantry where was one macameal that had one debox on the second showed meal that had of the box that expire shelfThere were two additional pantry was a pantry where two additional pantry in the pantry was a second boxed meal that had of the box that expire shelf.	re observed crawling on the antry. It roaches that fell out of the pasta was stored on the of pasta that had five dead in corner on the side of the relf. It roach on the top of the relf. It macaroni and cheese boxed and roach on the top of the relf. It macaroni and cheese one dead roach on the side do 03/19/21 on the second It ional boxes of macaroni expended, unsecured and not				
	Interview with the me Charge (MA/SIC) on revealed: -She was not aware t					
	roaches on several pa					
		y live roaches in the facility.				
	-When she saw the ty					
		get him, I spray him." Il items from the pantry and				
	spray with a flying ins					
		hour after she sprayed				
		lacing items in the pantry.				
		an the pantry as soon as				
	possible.					
	-She would notify the	Administrator if she felt a				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:			, , ,	E SURVEY PLETED		
		FCL008030	B. WING		06	R 6/ 22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PATHWAY	s		ARLES TAYLOR RO DER, NC 27805	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 257	-She did not realize the secure two boxes of a date them. Observation of the M 10:37am revealed she can with the label "Figure 10 Interview with the Add 2:10pm revealed: -A pest control compara a monthHe was not aware the in the pantryHe was shocked that in the pantryHe expected the MA was a problem with relative the facility. Review of a pest con revealed: -The service agreemed was signed and dated pest control companyThe service date lists 07/01/21. Requests for pest commonths from the Adm 2:10pm were not provided 22/21. The facility failed to emanner to prevent coby the presence of roces.	A/SIC on 06/17/21 at e held up an aerosol spray ying Insect Killer." ministrator on 06/21/21 at any sprayed the facility once at there were dead roaches t there were 2 live roaches /SIC to notify him if there	C 257			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:		SURVEY PLETED				
		FCL008030	B. WING		06	R 5/ 22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE	-	
PATHWAY	'S		ARLES TAYLOR RO DER, NC 27805	AD		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETE DATE
C 257	Continued From pag	e 34	C 257			
	and welfare of the re Type B Violation.	sidents, which constitutes a				
		a plan of protection in 1. 131D-34 on 07/12/21 for				
	CORRECTION DATI VIOLATION SHALL I 2021.	E FOR THE TYPE B NOT EXCEED AUGUST 6,				
C 912	G.S. 131D-21(2) Dec	claration of Residents' Rights	C 912			
	Every resident shall 2. To receive care a adequate, appropriate	ration of Resident's Rights have the following rights: nd services which are te, and in compliance with state laws and rules and				
	reviews, the facility factorial had the right to receive are adequate, appropriate and regular care and supervision exits, design and cor	as evidenced by: ns, interviews, and record ailed to ensure every resident ve care and services which priate, and in compliance itions as related to personal n, outside entrances and instruction, management and re and nutrition and food				
	The findings are:					
	reviews, the facility factor of 3 sampled resident dementia who exited knowledge and walk	tions, interviews, and record ailed to ensure supervision to ents (#1) with a diagnosis of the facility without staff ed to a home approximately acility with no shoes. [Refer				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	, ,	SURVEY PLETED
			A. BOILBING.			Б
		FCL008030	B. WING		06	R 5/ 22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
PATHWAY	'S	743 CHAF	RLES TAYLOR R	OAD		
FAIIIWAI	3	AULAND	ER, NC 27805			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 912	Continued From page	35	C 912			
	Care and Supervision	C 13G .0901(b) Personal (Type A2 Violation).]				
	2. Based on observat	ions, interviews and record				
		iled to ensure 2 of 2 exit				
		with a sounding device that				
	was audible througho was opened and acce	ut the facility when the door				
		diagnosis of dementia, was				
		ented and left the facility on				
	the morning of 06/09/	21 without staff knowledge.				
	[Refer to Tag 069 10A	(0)				
	Outside Entrances an	d Exits (Type B Violation)].				
	3. Based on observat	ions, interviews, and record				
		iled to ensure the residents'				
		s were in accordance with				
		ility listed on the facility's				
		f 4 sampled residents (#1)				
		pairments and required xit the facility during a fire				
		2 10A NCAC 13G .0302(b)				
		ion (Type B Violation)].				
	4. Based on observat	ions, interviews, and record				
	· · · · · · · · · · · · · · · · · · ·	iled to ensure sufficient staff				
	-	ake at all times to meet the				
		1 of 4 sampled residents				
	(#1) who had a diagno	ented and left the facility on				
		21 without staff knowledge.				
	[Refer to Tag 191 10A					
	Management and Oth	er Staff (Type B Violation)].				
	5. Based on observat	ions, interviews, and record				
		iled to ensure follow up for 1				
	of 3 residents sample					
		plaints of bilateral foot pain,				
		and fitting for proper shoes				

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Division of Health Service Regulation

PATHWAYS STREET ADDRESS, CITY, STATE, ZIP CODE 743 CHARLES TAYLOR ROAD AULANDER, NC 27805 (X4) ID PREFIX TAG 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)]. REQUIRATOR STREET ADDRESS, CITY, STATE, ZIP CODE 9 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE C 912 C 912 C 912 REQUIRATORY OR LSC IDENTIFYING INFORMATION) REQUIRATORY OR USE (Refer to Tag 246 10A NCAC 13G .0902(b) Health Care (Type B Violation)].	PATHWAYS SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG 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		ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
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