Division of Health Service Regulation

| 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 11/02/2016 |

| 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<br><br>The Adult Care Licensure Section and the Bertie County Department of Social Services conducted an annual survey and follow-up survey on November 2, 2016. | C 000 | All light bulbs have been Replaced throughout the facility by Administrator. Light bulb in 2nd Bathroom has been replaced on 11-4-16. Extra night lights have been placed throughout the facility by Administrator. SIC will contact maintance to change light bulbs that Require a ladder. photos have been made to show compliance. | |
| C 056 | 10A NCAC 13G .0309 (g) Bathroom<br><br>10A NCAC 13G .0309 Bathroom<br><br>g) The bathrooms shall be lighted to provide 30 foot candles of light at floor level and have mechanical ventilation at the rate of two cubic feet per minute for each square foot of floor area. These vents shall be vented directly to the outdoors<br><br>This Rule is not met as evidenced by:<br>Based on observation and interviews the facility failed to meet minimum lighting requirements in 1 of 2 resident bathrooms.<br><br>The findings are:<br><br>Observation on 11/02/16 at 7:55 AM revealed there were 2 resident bathrooms in the facility. Bathroom #1 was the main bathroom located in the hallway. Bathroom #2 was located in the master bedroom and shared by 2 residents.<br><br>Observation of bathroom #2 on 11/02/16 at 8:00 AM revealed:<br>-The light switch did not turn on the light.<br>-There was only 1 light fixture.<br>-The light fixture did not come on when the switch was turned on.<br>-There was no window for outside light.<br><br>The 2 residents that lived in the room had left for | C 056 | | |

Division of Health Service Regulation

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | Administrator | 11/26/16 |

STATE FORM 6899 UKV611 If continuation sheet 1 of 11

Reviewed & accepted 12/06/16 TS

RECEIVED DEC - 5 2016 ADULT CARE LICENSURE SECTION RALEIGH

| 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 11/02/2016 |

| 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 056 | Continued From page 1<br>the day and were not available for interview regarding the light fixture in their bathroom.<br><br>Interview with the Supervisor in Charge (SIC) on 11/02/16 at 8:10 AM revealed:<br>-She had just cleaned the bathrooms yesterday and the light was out in the bathroom 2.<br>-She had light bulbs but the light fixture was so high in the ceiling that the Maintenance man would have to do it.<br>-The light had been out for about a month.<br>-She would open the curtains in the bedroom so that it would provide enough light when she cleaned.<br>-The Maintenance man was behind because of the storm and had other things that were more of a priority.<br>-She would call the Maintenance man and have him come out to the facility to fix the light in bathroom 2.<br><br>Interview with the Maintenance man on 11/02/16 9:10 AM revealed:<br>-He tried to come to the facility about once a week.<br>-He had not been to the facility in a few weeks because he was working on repairs at another facility.<br>-The SIC would call him if there was something that needed to be fixed.<br>-He did not know about the lightbulb in bathroom #2.<br>-He would have to go get his ladder to change the bulb.<br><br>The Administrator was not available for interview on 11/02/16. | C 056 | | |

| 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 11/02/2016 |

| 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 078 | Continued From page 2 | C 078 | | |
| C 078 | 10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings<br><br>10A NCAC 13G .0315 Housekeeping and Furnishings<br>(a) Each family care home shall:<br>(5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards;<br>This Rule shall apply to new and existing homes.<br><br>This Rule is not met as evidenced by:<br>Observation of the kitchen on 11/02/16 at 7:50am revealed:<br>-There was a baseboard heater under the menu board in the kitchen and was part of the main walkway into the kitchen area.<br>-The metal front paBased on observations and interviews, the facility failed to assure the facility was kept free of hazards as evidenced by 2 partially detached baseboard heater panels with exposed metal edges in the living room and kitchen and a missing light switch cover in a residents' bathroom.<br>nel of the baseboard heater was partially detached from the heater on its right side.<br>-A sharp edge of the metal panel of the baseboard heater was exposed and bent away from the body of the heater approximately 1.5 inches.<br>-No residents were present in the kitchen area at the time.<br><br>Observation of the living room on 11/02/16 at 7:55am revealed:<br>-There was a baseboard heater under the front window of the living room.<br>-The metal front panel of the baseboard heater | C 078 | Partially Detached baseboard heater panels have been replaced by maintenance man on 11-4-16 with the assistance of Administrator in kitchen and livingroom. Metal edges have been repaired and edges fixed so sharp ends are covered on 11-4-16.<br><br>Missing light switch cover in Residents bathroom has been replaced by maintenance man on 11-4-16.<br><br>Base board heater has been properly mounded on wall | |

| 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 11/02/2016 |

| 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 078 | Continued From page 3<br>was partially detached from the heater on its left side that rested on the floor.<br>-A sharp edge of the metal panel was exposed and the metal panel was bent approximately 2 inches away from the body of the baseboard heater.<br>-Another section of the control panel from the right side for the baseboard heater was laying on the floor directly in the front of the heater.<br>-No visible wiring was exposed.<br>-No residents were present in the living room at the time.<br><br>Observation of bathroom #2 on 11/02/16 at 8:00am revealed:<br>-Bathroom #2 was located in the master bedroom and shared by 2 residents.<br>-There was a single light switch with no cover in bathroom #2 that had exposed internal wiring with an approximate 1.5 inch open area between the light switch and the drywall.<br>-The light switch was located above the sink used by the residents.<br>-The distance between the light switch and the top of the sink was approximately 12 inches.<br>-No residents were present in bathroom #2 or the bedroom at the time.<br><br>The 2 residents that lived in the room were not available for interview regarding the light switch cover in their bathroom.<br><br>Interview with the Supervisor in Charge (SIC) on 11/02/16 at 8:10 AM revealed:<br>-The baseboard heaters were used in the facility.<br>-She had not noticed the front panels were down on either of the baseboard heaters.<br>-One of the residents had probably knocked the panels off again because the residents like to prop their feet on the baseboard heater and | C 078 | on 11-4-16 By maintenance man.<br>Pictures sent for compliance | |

| 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 11/02/2016 |

| 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 078 | Continued From page 4<br>caused the front panels to come off.<br>-She would contact the Maintenance Man to come and fix the panels on the baseboard heaters again.<br>-She was unable to specify how many times the residents had knocked off the front panels of the baseboard heaters or how many times the panels had to be fixed.<br>-She did not know there was not a cover on the light switch in the bathroom #2.<br>-She had not noticed it and the residents had not told her about it.<br>-She would let the Maintenance Man know when she called him.<br><br>Interview with the Maintenance man on 11/02/16 at 9:10am revealed:<br>-The SIC would call him if there was something that needed to be fixed.<br>-He did not know about the missing cover for light switch in bathroom #2 because it had not been reported to him.<br>-He would go and get a cover for the light switch and put it on as soon as possible<br>-He did not know about the front panels on the baseboard heaters but he would fix the front panels as soon as he could.<br><br>The Administrator was not available for interview on 11/02/16. | C 078 | | |
| C 102 | 10A NCAC 13G .0317 (a) Building Service Equipment<br><br>10A NCAC 13G .0317 Building Service Equipment<br><br>(a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family | C 102 | | |

| 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 11/02/2016 |

| 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 102 | Continued From page 5<br>care home shall be maintained in a safe and operating condition<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the facility failed to assure all fire safety equipment in the facility was maintained in a safe and operating condition as related to 3 of 7 smoke detectors chirping and in need of new batteries. The findings are:<br><br>Observation of the facility 11/02/16 at 7:45 AM revealed:<br>-There were 7 smoke detectors throughout the facility.<br>-The smoke detector on the back hallway by the back exit door was chirping.<br>-The smoke detector on the front hallway in front of a resident's room was chirping.<br>-The smoke detector in the resident's room was chirping.<br><br>Interview with a resident on 11/02/16 at 9:30 AM that lived in the room with the chirping smoke detector revealed she did not hear the chirping.<br><br>Interview with the Supervisor in Charge (SIC) on 11/02/16 at 8:10 AM revealed:<br>-She had worked at the facility since it opened in 2012.<br>-She was the primary employee and worked 24 hours a day 7 days a week.<br>-She was not sure how long the smoke detectors had been chirping, but she just noticed it today (11/02/16).<br>-She would call the Maintenance man and have him come out to the facility.<br>-The Maintenance man was behind because of | C 102 | Batteries in all smoke detectors have been replaced by Administrative on 11-4-16. Smoke detector on the back hallway has been replaced and no detectors are chirping. Smoke detector on front hallway of Resident's Room and detector in Residents room have All Batteries been replaced. | |

| 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 11/02/2016 |

| 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 102 | Continued From page 6<br><br>the storm and had other things that were more of a priority.<br><br>Interview with the Maintenance man on 11/02/16 9:10 AM revealed:<br>-He tried to come to the facility about once a week.<br>-He had not been to the facility in a few weeks because he was working on repairs at another facility.<br>-The SIC would call him if there was something that needed to be fixed.<br>-He had not changed the batteries in the smoke detectors in about a year.<br>-He did not document when he changed the batteries.<br>-He would come change the batteries when 1 smoke detector started chirping.<br>-He would check all the batteries in the other smoke detectors once 1 started chirping.<br><br>Observation of the facility on 11/02/16 at 10:30 AM revealed 2 Maintenance men were changing the batteries in the smoke detectors.<br><br>The Administrator was not available for interview on 11/02/16. | C 102 | | |
| C 231 | 10A NCAC 13G .0801(b) Resident Assessment<br><br>10A NCAC 13G .0801Resident Assessment<br>(b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The | C 231 | New Assessment has been completed and signed by PCP. Copy sent to ensure compliance | |

| 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 11/02/2016 |

| 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 231 | Continued From page 7<br><br>assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the facility failed to assure an annual assessment and care plan was completed for 1 of 3 sampled residents (#1).<br><br>The findings are:<br><br>Review of Resident #1's current FL-2 dated 5/20/16 revealed diagnoses included Bipolar disorder mixed severe with psychotic features, cocaine abuse and cannabis dependence.<br><br>Review of Resident #1's Resident Register revealed he was admitted to facility on 7/13/13.<br><br>Review of assessment and care plan dated 5/20/15 for Resident #1 revealed:<br>-The primary care provider (PCP) signed the care plan on 5/19/16.<br>-An annual assessment and care plan was not completed after 5/19/15 for Resident #1.<br><br>Interview with the Supervisor in Charge (SIC) on | C 231 | Staff will place Assessment (careplan) in clear sleeve to prevent damage or loss of information while using Resident Information book. | |

| 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 11/02/2016 |

| 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 231 | Continued From page 8<br>11/02/16 at 9:00 AM revealed:<br>-She was responsible for keeping the resident's records in order.<br>-She completed all the resident's care plans.<br>-She completed a care plan annually on the same day she did the FL-2 and had it signed by the Primary Care Provider.<br>-She knew she had completed a care plan for Resident #1 but could not find it.<br>-There had been no significant changes with Resident #1.<br><br>The Administrator was not available for interview on 11/02/16. | C 231 | | |
| C 273 | 10A NCAC 13G .0904(d)(3)(A) Nutrition and Food Service<br><br>10A NCAC 13G .0904 Nutrition and Food Service<br>(d) Food Requirements in Family Care Homes:<br>(3) Daily menus for regular diets shall include the following:<br>(A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to provide homogenized milk to residents by serving diluted evaporated milk for consumption with the breakfast meal.<br><br>The findings are:<br><br>Review of the facility menu revealed an 8 ounce | C 273 | No staff member will not reconstituted dry milk or dilute evaporated milk for the purpose of drinking due to the risk of bacterial contamination. All staff of Pathways have been notified and are aware of the rule as of 11-2-2016. Administrator will monitor and maintain | |

| 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 11/02/2016 |

| 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 273 | Continued From page 9<br><br>serving of milk was listed to be served for breakfast, lunch and dinner meals.<br><br>Observation of the contents of the facility's refrigerator on 11/2/16 at 8:50am revealed 1 gallon container half filled with beige fluid that was not dated.<br><br>Interview with the Supervisor in Charge (SIC) on 11/2/16 at 8:55am revealed:<br>-She prepared all of the meals when she worked at the facility.<br>-She had mixed 2 cans of evaporated milk with a pitcher of water (unable to specific how much water) in the gallon container this morning so the residents would have milk with their cereal served at breakfast.<br>-The milk had ran out yesterday and she had forgot to call the administrator to let him know.<br>-She normally served the residents whole milk but she served diluted evaporated milk when the regular milk ran out but that was not done often.<br>-She could not specify how often she had served diluted evaporated milk to the residents in the past.<br>-She did not know she could not serve diluted evaporated milk to the residents in place of homogenized milk.<br>-She would call and let the Administrator know milk was needed at the facility.<br><br>Interviews with residents were not attainable since 5 residents left the facility for a day program prior to knowledge that diluted evaporated milk was being served in the facility. The one remaining resident in the facility was not able to be interviewed due to mental status.<br><br>The Administrator was not available for interview prior to the end of this survey. | C 273 | Homogenized whole, low fat, skim or buttermilk to be in facility for cooking or for food consumption weekly. Milk supply will be monitored weekly when groceries are purchased for 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 11/02/2016 |

| 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 |
|---|---|---|---|---|
| | | | | |