STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on April 01, 2021 and April 06, 2021.	C 000		
C 105	10A NCAC 13G .0317(d) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (d) The hot water tank shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, and laundry. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews the facility failed to ensure the hot water temperatures at 4 of 4 fixtures (sinks and tub/shower) used by and accessible to the residents in the kitchen, common bathroom and shared bathroom were maintained at a minimum of 100 degrees Fahrenheit (F) and did not exceed 116 degrees F including hot water temperatures as high as 127 degrees F. The findings are: Observation of the kitchen sink on 04/01/21 at 9:15am revealed: -The hot water temperature at the sink was 123 degrees F. -No steam was observed. Observation of the first shared residents'	C 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 105	Continued From page 1	C 105		

bathroom in the hallway on 04/01/21 at 9:05am revealed:
-The hot water temperature in the bathtub/shower was 127 degrees F.
-The hot water temperature at the sink was 120 degrees F.
-No steam was observed.

Interview with Resident #2 on 04/01/21 at 9:38am revealed:
-The water temperature was not too hot and not too cold.
-He usually mixed the hot and cold water together and he had not been burned by the water.

Observation of the second shared residents' bathroom in the hallway on 04/01/21 at 9:08am revealed:
-The hot water temperature at the sink was 123 degrees F.
-No steam was observed.
-The shower hot water knob was not working.

Interview with Resident #1 on 04/01/21 at 9:42am revealed:
-He had not had any problems with the water being too hot or too cold.
-He knew how to adjust the water temperature and check it before he got in the shower.

Observation of the facility's water heater on 04/01/21 at 9:58am revealed a digital reading of 125 degrees F.

Second observation of the facility's water heater on 04/01/21 at 10:45am revealed a digital reading of 125 degrees F.

Review of the Department of Health and Human Services (DHHS) factors to be considered when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 105	Continued From page 2	C 105		

analyzing hot water safety issues in resident care areas of adult care facilities (not dates) revealed a water temperature of 127.4 degrees F can result in a first degree burn in 30 seconds and a second degree burn in 60 seconds.

Interview with a personal care aide (PCA) on 04/01/21 at 9:31am revealed:
-The Manager was responsible for checking the hot water temperatures.
-He did not know how often the hot water temperatures were checked.

Review of the facility's water temperature log on 04/01/21 revealed:
-On 01/07/21, the water temperature was 112 degrees F in the kitchen and 111 degrees F in both of the residents' shared bathrooms in the hallway.
-On 01/14/21, the water temperature was 113 degrees F in the kitchen and 112 degrees F in both of the residents' shared bathrooms in the hallway.
-On 01/21/21, the water temperature was 112 degrees F in the kitchen and 112 degrees F in both of the residents' shared bathrooms in the hallway.
-On 01/28/21, the water temperature was 113 degrees F in the kitchen and 112 degrees F in both of the residents' shared bathrooms in the hallway.
-On 02/04/21, the water temperature was 112 degrees F in the kitchen and 111 degrees F in both of the residents' shared bathrooms in the hallway.
-On 02/11/21, the water temperature was 110 degrees F in the kitchen and 112 degrees F in both of the residents' shared bathrooms in the hallway.
-On 02/18/21, the water temperature was 112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 105	Continued From page 3	C 105		

degrees F in the kitchen and 113 degrees F in both of the residents' shared bathrooms in the hallway.
-On 02/25/21, the water temperature was 113 degrees F in the kitchen and 112 degrees F in both of the residents' shared bathrooms in the hallway.
-On 03/04/21, the water temperature was 112 degrees F in the kitchen and 111 degrees F in both of the residents' shared bathrooms in the hallway.
-On 03/11/21, the water temperature was 113 degrees F in the kitchen and 112 degrees F in both of the residents' shared bathrooms in the hallway.
-On 03/18/21, the water temperature was 112 degrees F in the kitchen and 112 degrees F in both of the residents' shared bathrooms in the hallway.
-On 03/25/21, the water temperature was 113 degrees F in the kitchen and 112 degrees F in both of the residents' shared bathrooms in the hallway.
-There was no other documentation of water temperature reading for the kitchen and shred resident's bathrooms after 03/25/21.

Recheck of hot water temperature in the kitchen on 04/01/21 at 10:43am revealed:
-The hot water temperature at the sink had increased to 125 degrees F.
-No steam was observed.

Recheck of the hot water temperatures of the first residents' common bathroom on 04/01/21 at 10:35am revealed:
-The hot water temperature at the sink had increased to 125 degrees F with visible steam.
-The hot water temperature in the bathtub/shower had increased to 129 degrees F with visible

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 105	Continued From page 4 steam. Recheck of the hot water temperatures of the second residents' common bathroom on 04/01/21 at 10:41am revealed: -The hot water temperature at the sink had increased to 125 degrees F. -The shower knob was not working. -No steam was observed. Observation of the Manager attempting to turn down the temperature on the water heater on 04/01/21 at 10:47am revealed: -There was a digital reading of 125 degrees F. -The Manager was unable to turn the water heater's temperature down. Calibration of the surveyor's thermometer on 04/01/21 at 10:57am in a cold water slurry revealed the thermometer displayed 32 degrees F. The facility did not have a working thermometer present at the time of calibration. Interview with the Manager on 04/01/21 at 12:20pm revealed: -She checked the hot water temperature weekly. -She last checked the hot water temperature on 03/25/21 and they were not too hot. -The temperatures ranged around 113 degrees F. -She knew the required range for the hot water temperatures were 100 degrees F to 116 degrees F. -She just needed to turn down the thermostat on the water heater. -She would turn the water temperature down on the hot water heater. Interview with the Manager on 04/01/21 at 11:46am revealed: -She was unable to turn down the thermostat on	C 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 105	Continued From page 5 the water heater. -She had reported to the Administrator. Attempted telephone interview with the Administrator on 04/01/21 at 1:41pm was unsuccessful. _____ The facility failed to ensure hot water temperatures for 4 of 4 fixtures used by residents were maintained between 100 - 116 degrees F. The water temperatures ranged from 120 degrees F to 129 degrees F. A water temperature of 127.4 degrees F can result in a first degree burn in 30 seconds and a second degree burn in 60 seconds. The failure of the facility to ensure water temperatures were between 100 - 116 degrees F was detrimental to the safety, health and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/01/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 21, 2021.	C 105		
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;	C 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 145	Continued From page 6 This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure 1 of 3 sampled staff (Staff C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of Staff C's personnel record revealed: -Staff C was hired as a personal care aide (PCA) on 08/16/19. -There was documentation of a Health Care Personnel Registry (HCPR) check dated 01/25/20. -There was no documentation of a HCPR check being completed when Staff B was hired on 08/16/19. Telephone interview with Staff C on 04/06/21 at 3:10pm revealed: -She started working at the facility on 10/31/19 as a PCA. -She cooked, cleaned and monitored the residents. -She worked alone with the residents. -The Manager came in to give the residents their medications. -She did not know if the facility did a HCPR check when she was hired. Interview with the Manager on 04/06/21 at 9:37am revealed: -Staff C had worked at the facility as a PCA for 2 years. -Staff usually started to work about a week after the hire date. -The Administrator was responsible for completing the HCPR checks. -The Administrator was responsible for personal	C 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 145	Continued From page 7 record audits. Attempted telephone interview with the Administrator on 04/06/21 at 12:51pm was unsuccessful.	C 145		
C 201	10A NCAC 13G .0701 (b) Admission Of Residents 10A NCAC 13G .0701 Admissions Of Residents (b) Exceptions. People are not to be admitted: (1) for treatment of mental illness, or alcohol or drug abuse; (2) for maternity care; (3) for professional nursing care under continuous medical supervision; (4) for lodging, when the personal assistance and supervision offered for the aged and disabled are not needed; or (5) who pose a direct threat to the health or safety of others. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled residents (Resident #3) was not admitted for the treatment of a mental illness. The findings are: Review of Resident #1's current FL2 dated 06/22/20 revealed: -Diagnosis included schizophrenia. -The resident was documented as ambulatory. -There was no information related to orientation status.	C 201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 201	Continued From page 8	C 201		

-The recommended level of care was domicillary.
-There was no other documented diagnosis.

Review of Resident #3's Resident Register revealed no admission date but was signed on 06/22/20.

Review of Resident #1's care plan dated 06/22/20 revealed:
-The resident was documented as oriented with adequate memory.
-The resident was documented as independent with eating, toileting, ambulation, bathing, dressing, grooming, and transferring.
-There was no documentation of the resident receiving mental health services.
-There was no documentation regarding the resident's mental health history or current status.

Telephone interview with Resident #1's family member on 04/06/21 at 3:03pm revealed:
-Resident #1 was admitted to the facility because of his behavioral health issues.
-Resident #1 did not have any medical problems.
-Resident #1 had moved to the facility from a group home.
-She thought the current facility was a group home.

Telephone interview with Resident #1's mental health provider (MHP) on 04/06/21 at 03:26pm revealed:
-Resident #1 was last seen by the provider on 03/17/21.
-Resident #1's only diagnosis was schizophrenia.
-The only medications listed for Resident #1 were behavioral health medications.

Interview with the Manager on 04/06/21 at 4:06pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 201	Continued From page 9 -Resident #1 was admitted on 06/22/20 from another facility that had closed. -The facility was Resident #1's home and he was not waiting for other placement. -Resident #1 had no medical problems. -Resident #1 only had mental health issues and only took mental health medications. -Resident#1 was being followed by behavioral health. -The Administrator was responsible to review all admission paperwork to see if the residents were appropriate for placement. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 04/06/21 at 11:36am was unsuccessful. Attempted telephone interview with the Administrator on 04/06/21 at 12:51pm was unsuccessful.	C 201		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.	C 202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 202	Continued From page 10 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled residents (#3) had completed tuberculosis (TB) skin testing upon admission in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #3's current FL-2 dated 08/01/20 revealed diagnoses included schizoaffective disorder, hypertension, mild persistent asthma and tobacco abuse. Review of Resident #3's Resident Register dated 08/21/20 revealed Resident #3 was admitted on 07/29/20. Review of Resident #3's record revealed: -There was no documentation of a completed tuberculosis (TB) skin testing. -There was documentation of a fax from a hospital dated 03/18/21 documenting the hospital has no TB test results for Resident #3. Review of a fax sent from the Administrator dated 04/05/21 revealed: -The Administrator contacted Resident #3's previous home on 04/04/21 requesting the TB skin test results. -There was no TB skin test documented. -The Administrator requested Resident #3's Primary Care Provider (PCP) to give an order for a chest X-ray (date not provided). Interview with Resident #3 on 04/01/21 at 4:19pm revealed: -He had a positive TB skin test in the past (date unknown).	C 202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 202	Continued From page 11	C 202		

-He last had a chest x-ray in 2017 because he had tested positive for TB.
-No one at the facility had ever asked him if he had tested positive for TB when he was admitted to the facility.
-No one at the facility had said anything to him about getting a chest x-ray or testing him for TB.

Telephone interview with Resident #3's family member on 04/01/21 at 6:16pm revealed:
-Resident #3 had a positive history of TB.
-Resident #3 had tested positive for TB in 1987 or 1988.

Attempted telephone interview with Resident #3's Primary Care Provider (PCP) on 04/06/21 at 11:36am was unsuccessful.

Interview with the Manager on 04/01/21 at 4:16pm revealed:
-She made sure the residents' records were up to date.
-She looked for the TB skin test when Resident #3 was admitted and could not find one.
-She told the Administrator a week ago that Resident #3 did not have a TB skin test in the record.
-She called the local health department a week ago trying to get him an appointment for a TB test.

Telephone interview with the Administrator on 04/01/21 at 4:22pm revealed:
-Resident #3 did not have a TB test upon admission.
-He was trying to get Resident #3 an appointment for a chest x-ray but due to COVID-19 he was unable to.
-He thought Resident #3 had an appointment for a chest x-ray next week.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 202	Continued From page 12 -He was trying to set up a TB screening for Resident #3 today. -He was responsible for making sure the residents had the TB test upon admission. -Resident #3's TB status was unknown. -Resident #3 did not have a positive history of TB as far as he knew. -He asked Resident #3 on admission if he had a positive history of TB and he told him no.	C 202		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care And Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, and record reviews, the facility failed to provide supervision for 1 of 3 residents sampled related to the resident walking away from the facility without staff's knowledge (Resident #1). The findings are: Review of Resident #1's current FL2 dated 06/22/20 revealed: -Diagnoses included schizophrenia. -The resident was documented as ambulatory. -There was no orientation status documented. Review of Resident #1's care plan dated 06/22/20 revealed: -The resident was documented as oriented with	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 13	C 243		

adequate memory.
-The resident was documented as independent with eating, toileting, ambulation, bathing, dressing, grooming, and transferring.
-There was no documentation of the resident receiving mental health services.
-There was no documentation regarding the resident's mental health history or current status.

Review of the facility's sign-out registry on 04/01/21 at 5:56pm revealed there was no documentation of Resident #1 signing out of the facility on 03/22/21.

Interview a Resident #1 on 04/06/21 at 8:39am revealed:
-He last walked away from the facility two weeks ago and did not sign out of the facility.
-He walked a few miles down to the end of the road.
-He had walked away from the facility on two other occasions (date unknown).
-No one from the facility came to look for him.
-He returned to the facility own his own.
-The staff did not say anything to him when he returned to the facility.
-He could leave the facility if he signed himself out.

Interview with a personal care aide (PCA) on 04/01/21 at 5:37pm revealed:
-Resident #1 walked away from the facility on 03/22/21 around lunch time.
-Resident #1 did not sign out of the facility.
-Law enforcement were called.
-Law enforcement picked him up in the next town and brought him back.
-Resident #1 was gone for about 30 minutes.
-The Manager was notified that Resident #1 had walked away from the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 14 Interview with a second PCA on 04/06/21 at 3:10pm revealed: -Staff were supposed to call the Manager if the resident eloped. -The Manager would tell staff to wait a few minutes and see if the resident returned. -She would wait 30 to 45 minutes to see if the resident came back -Staff did not know where the residents were going if the residents did not sign out. Telephone interview with Resident #1's family member on 04/06/21 at 12:42pm revealed: -The facility called last week and told her Resident #1 had walked away from the facility and the police brought him back. -Resident #1 was gone for 30 minutes to an hour. -Resident #1 had to be supervised. -Resident #1 would sometimes forget where he was and needed to be reminded. -The family member was Resident #1's guardian. -She did not want Resident #1 to leave the facility unsupervised. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 04/06/21 at 11:36am was unsuccessful. Telephone interview with Resident #1's mental health providers (MHP) on 04/06/21 at 03:26pm revealed: -Resident #1 was last seen by the provider on 03/17/21. -There was no documentation of Resident #1's orientation status. -There was documentation of Resident #1 had delusional thoughts and poor judgement. Interview with the Manager on 04/01/21 at	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 15 5:58pm revealed: -Resident #1 had walked away on 03/22/21. -She called the Administrator and the Administrator told her to call Law enforcement. -She called the police because she did not know where Resident #1 went or how long he would be gone. _____ The facility failed to ensure 1 of 3 residents who had delusional thoughts and poor judgement was provided staff supervision when he eloped from the facility and law enforcement had to be called to find Resident #1 in the next town. The facility's failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/06/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 21, 2021.	C 243		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the mental health providers (MHP) for 1 of 3 residents sampled regarding a resident who eloped and law enforcement had to bring back to the facility.	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 16 The findings are: Review of Resident #1's current FL2 dated 06/22/20 revealed: -Diagnoses included schizophrenia. -The resident was documented as ambulatory. -There was no orientation status documented. Review of Resident #1's care plan dated 06/22/20 revealed: -The resident was documented as oriented with adequate memory. -The resident was documented as independent with eating, toileting, ambulation, bathing, dressing, grooming, and transferring. -There was no documentation of the resident receiving mental health services. -There was no documentation regarding the resident's mental health history or current status. Interview with a personal care aide (PCA) on 04/01/21 at 5:37pm revealed: -Resident #1 walked away from the facility on 03/22/21 around lunch time. -Resident #1 did not sign out of the facility. -Law enforcement were called. - Law enforcement picked him up in the next town and brought him back. -Resident #1 was gone for about 30 minutes. -The Manager was notified that Resident #1 had walked away from the facility. Telephone interview with Resident #1's mental health provider (MHP) on 04/06/21 at 03:26pm revealed: -Resident #1 was last seen by the provider on 03/17/21. -There was no documentation of Resident #1's orientation status. -There was documentation of Resident #1 had	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 17 delusional thoughts and poor judgement. -The provider had not been notified of Resident #1 elopement from the facility. Interview with the Manager on 04/01/21 at 5:58pm revealed: -Resident #1 had walked away on 03/22/21. -She called the Administrator and the Administrator told her to call Law enforcement. -She called Law enforcement because she did not know where Resident #1 went or how long he would be gone. -Resident #1 did not sign himself out of the facility. Interview with the Manager on 04/01/21 at 6:18pm revealed: -She had not notified Resident #1's PCP nor his MHP of his elopement on 03/22/21. -She was responsible for notifying Resident #1's PCP and MHP of the elopement. -She did not realize she had to notify them of the elopement.	C 246		
C 301	10A NCAC 13G .0906 (f)(1)-(4) Other Resident Services 10A NCAC 13G .0906 Other Resident Services (f) Visiting. (1) Visiting in the home and community at reasonable hours shall be encouraged and arranged through the mutual prior understanding of the residents and administrator; (2) There must be at least 10 hours each day for visitation in the home by persons from the community. If a home has established visiting hours or any restrictions on visitation, information about the hours and any restrictions must be	C 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 301	Continued From page 18 included in the house rules given to each resident at the time of admission and posted conspicuously in the home; (3) A signout register must be maintained for planned visiting and other scheduled absences which indicates the resident's departure time, expected time of return and the name and telephone number of the responsible party; (4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home must immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to immediately notify the local county Department of Social Services (DSS) when the whereabouts of a resident was unknown (#1). The findings are: Review of Resident #1's current FL2 dated 06/22/20 revealed: -Diagnoses included schizophrenia. -The resident was documented as ambulatory. -There was no orientation status documented. Review of the facility's sign-out registry on 04/01/21 at 5:56pm revealed there was no documentation of Resident #1 signing out of the facility on 03/22/21. Interview with a personal care aide (PCA) on	C 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 301	Continued From page 19	C 301		

04/01/21 at 5:37pm revealed:
-Resident #1 walked away from the facility on 03/22/21 around lunch time.
-Resident #1 did not sign out of the facility.
-Law enforcement were called.
-Law enforcement picked him up in the next town and brought him back.
-Resident #1 was gone for about 30 minutes.
-The Manager was notified that Resident #1 had walked away from the facility.

Review of the local county DSS staff notes dated 04/05/21 revealed:
-The Manager called and reported a resident walked away from the facility sometime in March 2021 and did not sign out.
-The Manager did not know she had to complete an incident/accident report when a resident walked away from the facility.
-The Manger reported contacting the law enforcement department and the responsible party.
-The Manager did not know that the resident walking away from the facility was an incident.
-The Manager was encouraged to fax an incident report to the local DSS office.

Telephone interview with local DSS staff on 04/06/21 at 2:10pm revealed:
-The Manager called on 04/05/21 to notify DSS staff of Resident #1 walking away from the facility and not signing out in March 2021.
-DSS had not received any incident and accident reports from the facility as of 04/06/21.
-DSS staff expected to be notified of a resident elopement immediately.

Interview with the Manager on 04/01/21 at 5:58pm revealed:
-Resident #1 had walked away on 03/22/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 301	Continued From page 20 -She called the Administrator and the Administrator told her to call the law enforcement. -She called the police because she did not know where Resident #1 went or how long he would be gone. -Resident #1 did not sign himself out of the facility. -She had not completed an incident and accident report. -She and the Administrator were responsible for completing incident and accident reports and notifying DSS. Interview with the Manager on 04/01/21 at 6:18pm revealed: -She did not notify DSS of Resident #1's elopement on 03/22/21. -She was responsible for notifying the local DSS. -She did not realize she had to notify them of the elopement.	C 301		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure residents at the facility were treated with respect and dignity as evidence by staff member (Staff B) disrespecting residents, intimidating residents and requiring residents to stay outside after smoking and requiring resident to stay in their room until breakfast was severed.	C 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 311	Continued From page 21 The findings are: 1.Observation of the living room of the facility on 04/01/21 at 5:13pm revealed: -Resident #2 was standing in the doorway of the living room leading to the kitchen. -Staff B was standing in the kitchen and said to the resident "you told me 3 times you were not eating" in a loud tone. -Resident #2 walked into the living room and sat on the couch. -Staff B walked through the living room and into the Manager's office stating loudly "he told me 3 times he was not going to eat". Interview with Resident #2 on 04/01/21 at 5:15pm revealed: -Staff B spoke to him any way they want to. -Staff B cursed at him and act like he was going to jump on him and fight him. -Staff B spoke to him like this every day. -It made him feel mad, angry and upset. Observation of the kitchen/dining room on 04/01/21 at 5:19pm revealed: -Staff B reentered the living room walked up and stood over Resident #2 less than 2 feet in front of him and said "come on" loudly. -Resident #2 entered the kitchen and sat at the table where the other five residents were sitting, and the Manager was standing in the kitchen. -As Resident #2 was sitting down at the table Staff B tossed Resident #2's plate of food on the table. -Resident #2 asked Staff B for a spoon to eat with and Staff B tossed the spoon on the table next to Resident #2. Interview with a resident on 04/06/21 at 8:39 pm	C 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 311	Continued From page 22	C 311		

revealed:
-Staff B talked to the all the residents in the facility the same way he talked to Resident #2 about the food.
-Staff B would tell him "you better hurry up and eat before someone hits you in your mouth" (date unknown).
-He felt "a little scared "of Staff B and thought Staff B was going to beat him up.
-He had never told the Manager.

Interview with a second resident on 04/06/21 at 8:50am revealed:
-Staff B and the Manager talked to the residents like they were "little".
-If they did not understand what we were saying they would say "can't you talk with any sense".
-The staff had been talking to the residents like that since he came to the facility over four years ago.

Interview with Staff B on 04/01/21 at 5:37pm revealed:
-When he started cooking dinner, Resident #2 told him that he was not going to eat dinner.
-Then Resident #2 came in the kitchen and said he was going to eat dinner.
-Resident #2 did not eat the food and he thought it was a waste of time to fix it for him when he did not eat the food.
-He did not talk back to the residents unless they continuously come behind him and then he felt like he had to say something back.
-It was wrong for him to throw Resident #2's plate and spoon on the table.
-"The way I told Resident #2 to come on was disrespectful".
-"The way I talked to Resident #2 was wrong".

Interview with a personal care aide (PCA) on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 311	Continued From page 23	C 311		

04/06/21 at 3:10pm revealed:
-Some of the residents had told her that Staff B yelled at the residents about a month ago.
-The Manager knew how Staff B talked to the residents.

Interview with the Manager on 04/01/21 at 5:24pm revealed:
-The residents told her Staff B has an attitude problem.
-She had talked with the Administrator about Staff B's attitude towards the residents about 3 months ago.
-She did not expect Staff B to disrespect Resident #2 the way he did because the resident changed his mind and wanted to eat.
-The way Staff B talked to Resident #2 was really disrespectful and the way Staff B threw the resident's plate and spoon on the table was also really disrespectful.
-Resident #2's plate and spoon should have been placed on the table and not thrown on the table.
-Staff should not argue with the residents.

Telephone interview with the Administrator on 04/06/21 at 1:10pm revealed:
-The Manager had called him and told him about what happened with Staff B and Resident #2 on 04/01/21.
-The Manager told him that Staff B had thrown the plate on the table to Resident #2.
-He talked with Staff B on 04/01/21 and Staff B explained that it was not what it looked like.

2. Interview with a resident on 04/01/21 at 9:38am and 3:05pm revealed:
-He had lived at the facility for ten years.
-He had to stay in his room until breakfast was served at 10:00am for the last ten years.
-He could go to the bathroom and get water, but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 311	Continued From page 24	C 311		

he had to go back to his room until breakfast was served.
-Staff made the residents stay in our rooms in the morning and did not allow us to go in the TV room.
-It made me feel upset and it is against my rights.

Interview with a second resident on 04/01/21 at 9:42am and 3:19pm revealed:
-He lived at the facility for about a year.
-He had to stay in his room in the mornings until breakfast was served at 10:00am.
-Staff told him he had to stay in his room, but he did not know why.
-He went out of his room before breakfast once to watch TV and Staff B told him to go back to his room.
-He just followed the rules.
-The Manager told him he had to stay in his room in the morning until breakfast was served when he was admitted to the facility about a year ago.
-"I can't do it, it's too much on me".

Interview with a third resident on 04/01/21 at 9:45am and 3:29pm revealed:
-He had to stay in his room in the mornings until breakfast.
-He was not sure what time breakfast was served.
-If he went out of his room before breakfast staff would tell him to "go back to your room, go back to your room".
-It made him feel like a child to have to stay in his room and being told to go back to his room.
-He just did what the staff said to do but he did not think the staff should be talking to him like that.

Interview with a fourth resident on 04/01/21 at 3:44pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 311	Continued From page 25 -He got up in the morning around 9:00am and he had to stay in his room until staff fixed breakfast at 10:00am. -He would go along with the rules. Interview with a fifth resident on 04/06/21 at 8:50am revealed: -In the morning he could not leave his room until 10:00am if he did not have to go to school. -He did not like having to stay in his room until 10:00am, but he did it. -Staff had not told him why he had to stay in his room. Interview with a personal care aide (PCA) on 04/01/21 at 11:45am revealed: -He had worked at the facility for 8 years. -The residents had to stay in their rooms until 10:00am and wait until breakfast was ready on the days, they did not have school. -The residents had not had school in over a year. -Some of the residents got up at 4:00am and would cut the lights in the facility on and wake the other residents. -"If I tell the residents they can get up in the mornings and come out of their rooms they would do it every day". -The Manger told him when he was hired eight years ago to make the resident's stay in their rooms until 10:00am. Interview with the Manager on 04/06/21 at 9:37am revealed: -She did not know the residents were not allowed to leave their rooms in the morning until breakfast. -The residents had the right to leave out of their room when they got ready. -She had not told the staff to keep the resident's in their room until 10:00am.	C 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 311	Continued From page 26 -The residents had not told her that the staff made them stay in their room until breakfast was ready. 3. Interview with a resident on 04/01/21 at 9:38am revealed: -He could go outside to smoke after breakfast but when he went outside to smoke, he had to stay outside for an hour before he was allowed to come back into the facility. -When it was raining outside, he had to smoke on the back porch, if it was cold, he had to put on a coat and if it was hot he would have to go under the shade tree, but regardless of the weather he would have to wait an hour before he could return inside. Interview with a second resident on 04/01/21 at 9:42am revealed: -When he went outside to smoke, he had to stay outside for an hour before he could come back into the facility. -If he tried to go inside the facility before the hour staff would tell him to go to his room and lay down for 2 hours which staff called "a break". -He came in the facility before his hour was up from smoking and staff made him take a "break" about a week ago. -In the summertime the staff brought the water cooler outside for us. Interview with a third resident on 04/01/21 at 3:44pm revealed he had to stay outside for an hour or more after he went outside to smoke when it was warm outside. Interview with a fourth resident on 04/01/21 at 3:29pm revealed if he went outside to smoke, he had to stay outside for an hour before he could come back in the facility.	C 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 311	Continued From page 27 Interview with a fifth resident on 04/06/21 at 8:50am revealed: -When he went outside to smoke, he had to stay outside for an hour before he was allowed to come back into the facility. -In the summer he had to sit under the shade tree at the picnic table and when it was cold they could sometimes come back into the facility before the hour was up. -Staff had not told him why he had to stay outside for an hour after he smoked. Interview with a personal care aide (PCA) on 04/01/21 at 11:45am revealed: -The residents had to stay outside for one and a half hours before they can come back into the facility in the summertime after smoking. -The residents would keep going inside and outside the facility and let the bugs in and let the air conditioning out. -The Administrator and the Manager told him to keep the residents outside for one hour and a half in the summertime after smoking. Interview with a second PCA on 04/06/21 at 3:10pm revealed: -The residents had to stay outside for at least an hour after they went outside to smoke. -When it was cold outside, she would let the residents back into the facility before the hour was up. -The Manager told her to keep the residents outside for at least an hour after they go outside to smoke. Interview with the Manager on 04/01/21 at 5:24pm revealed: -She did not know staff was making the residents stay outside for a hour to a hour and a half before	C 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 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 311	Continued From page 28 the resident could come back in the facility after smoking a cigarette. -A hour and a half was too long for the residents to be made to stay outside in the heat. -The residents would get sick if they were made to stay out in the cold for that long. -She had never trained staff to make the residents stay out for an hour to a hour and a half after smoking be for the residents could come back inside the facility. -Today was the first time she had heard about this. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 04/06/21 at 11:36am was unsuccessful. _____ The facility failed to ensure the residents were treated with dignity and respect related to one resident who was talked to aggressively and disrespectfully by Staff B and felt intimidated by Staff B; made to stay in their rooms until breakfast was ready and made to stay outside for an hour to an hour and a half after smoking. The facility's failure was detrimental to the resident's safety and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G. S. 131D-34 on 04/01/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 21, 2021.	C 311		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights	C 912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 912	Continued From page 29 Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to building service equipment, personal care and supervision. The findings are: 1. Based on observations and interviews the facility failed to ensure the hot water temperatures at 4 of 4 fixtures (sinks and tub/shower) used by and accessible to the residents in the kitchen, common bathroom and shared bathroom were maintained at a minimum of 100 degrees Fahrenheit (F) and did not exceed 116 degrees F including hot water temperatures as high as 127 degrees F. [Refer to Tag 105 10A NCAC 13G .0317(d) Building Service Equipment (Type B Violation)]. 2. Based on interviews, and record reviews, the facility failed to provide supervision for 1 of 3 residents sampled related to the resident walking away from the facility without staff's knowledge (Resident #1). [Refer to Tag 243 10A NCAC 13G .0901 Personal Care and Supervision (Type B Violation)]. 3.Based on observations and interviews, the facility failed to ensure residents at the facility were treated with respect and dignity as evidence	C 912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008001	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHWAYS II	812 CHARLES TAYLOR ROAD AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 912	Continued From page 30 by staff member (Staff B) disrespecting residents, intimidating residents and requiring residents to stay outside after smoking and requiring resident to stay in their room until breakfast was severed. [Refer to Tag 0311 10A NCAC 13G .0909 Resident Rights (Type B Violation)].	C 912		