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
	FCL008001	A. BUILDING: _____ B. WING _____	R 07/30/2021

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 a follow-up survey on 07/30/21.	{C 000}		
{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 #1) 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. -The recommended level of care was domiciliary. -There was no other documented diagnosis.	{C 201}	• Facility will only admit Adults over the age of 18 who have Chronic physical condition or mental disability, needs A substitute home, in the opinion of the Resident, physician, family or social worker. Services And Accomodations of the home	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 8/12/2021

Recieved & acknowledged 10/04/21
by K Bennett RN

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{C 201}	Continued From page 1 Review of Resident #1'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. Interview with the Manager on 07/30/21 at 2:34pm at revealed: -Resident #1 was admitted on 06/22/20 from another facility that had closed. -The facility was not looking for other placement for Resident #1. -Resident #1 had no medical problems. -Resident #1 only had mental health issues. -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. -Resident #1's family member was afraid of him because he had aggressive behaviors. Telephone interview with Resident #1's family member on 07/30/21 at 3:09pm revealed: -Resident #1 was admitted to the facility because of his behavioral health issues such as punching holes in the walls, delusional and threatening to harm himself and others. -Resident #1 did not have any medical problems. -Resident #1 had moved to the facility from a	{C 201}	meet particular needs of the adult. • Facility will only Admit Adults who have a mental disability defined by physician, family, or social worker. • Nurse will Review future placements to ensure only Adults with mental disability defined by physician or social worker. • Monitoring will take place prior to Admissions. • Completed 8-2021	

Vandiver 8/22/21 administrator

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{C 201}	Continued From page 2 group home. Attempted telephone interview with Resident #1's mental health provider (MHP) on 07/30/21 at 3:05pm was unsuccessful. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 07/30/21 at 3:07pm was unsuccessful. Telephone interview with the Administrator on 07/30/21 at 4:01pm revealed: -Resident #1 had no medical problems. -Resident #1 needed assistance with medication administration but was independent with personal care needs. -Treatment for Resident #1's mental illness was provided by Resident #1's psychiatrist, not the facility. -There were no plans to look for other placement for Resident #1.	{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}		

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{C 202}	Continued From page 3 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled residents (#1) 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 #1's current FL2 dated 06/22/20 revealed diagnosis included schizophrenia. Review of Resident #1's Resident Register revealed no admission date but was signed on 06/22/20. Review of Resident #1's record revealed there was no documentation of a completed tuberculosis (TB) skin testing. Interview with Resident #1 on 07/30/21 at 4:20pm revealed: -He had a TB skin test placed but could not remember when. -He did not know if the test results were positive or negative. Telephone interview with Resident #1's family member on 07/30/21 at 3:09pm revealed: -She thought he had a TB skin test but could not remember when it had been placed. -She was not aware of Resident #1 ever testing positive or being tested for TB. Attempted telephone interview with Resident #1's mental health provider (MHP) on 07/30/21 at 3:05pm was unsuccessful.	{C 202}	• Facility will have Nurse Review patient orders prior to placement to ensure At least one TB skin test before Admission. • Nurse will Review records prior to Admission to ensure one TB skin test has been completed And there is documentation for proof. • Nurse will Review records before Admission to ensure documentation of TB skin test or Chest Xray. • Prior to Admission to ensure one documented TB skin test OR Chest Xray has been completed. • 8-20-21 Completion Date.	

Vandella Cp. admistator 8/22/21

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{C 202}	Continued From page 4 Interview with the Manager on 07/30/21 at 2:34pm and 3:19pm revealed: -She was responsible for resident records. -She knew he had TB skin test on admission when he came to the facility from the previous facility. -She was unable to find the TB skin test on admission to the facility for Resident #1. Telephone interview with the Administrator on 07/30/21 at 4:01pm revealed: -Resident #1 did have a TB test upon admission and should be in the resident record. -He was responsible for making sure the residents had the TB test upon admission.	{C 202}		
C 203	10A NCAC 13G .0702 (b) Tuberculosis Test And Medical Examination 10A NCAC 13G .0702 Tuberculosis Test And Medical Examination (b) Each resident shall have a medical examination prior to admission to the home and annually thereafter. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure a medical examination was completed annually with results documented on an FL-2 for 1 of 3 sampled resident (Resident #1). Review of Resident #1's current FL2 dated 06/22/20 revealed: -Diagnosis included schizophrenia.	C 203	• Administrator will ensure All Residents have A Annual exam documented on FL2 and Health Service Report • Administrator will review records quarterly to ensure medical exam has been completed. • Administrator will monitor Resident Records. • Administrator will reviews Records quarterly to ensure medical exam has been completed.	

Vaughn C Jr. administrator 8/22/21

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C 203	Continued From page 5	C 203	- Completed on 8-20-21	

-The resident was documented as ambulatory.
-There was no information related to orientation status.
-The recommended level of care was domiciliary.
-There was no other documented diagnosis.

Review of Resident #1'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.

Interview with the Manager on 07/30/21 at 2:34pm at revealed:
-Resident #1 was admitted on 06/22/20 from another facility that had closed.
-Resident #1 had no medical problems.
-Resident #1 only had mental health issues.
-Resident#1 was being followed by behavioral health.
-She was responsible for ensuring FL-2's were current for the residents at the facility.
-She was aware Resident #1's FL-2 was not updated.
-She reviewed resident records monthly
-The primary care provider (PCP) was refusing to see Resident #1 because they did not have a copy of his insurance card.
-The facility was looking for a new PCP but did not have an appointment date.

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C 203	Continued From page 6 Attempted telephone interview with Resident #1's mental health provider (MHP) on 07/30/21 at 3:05pm was unsuccessful. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 07/30/21 at 3:07pm was unsuccessful. Telephone interview with the Administrator on 07/30/21 at 4:01pm revealed: -Resident #1 had no medical problems. -Resident #1 needed assistance with medication administration but was independent with personal care needs. -The manager was responsible for ensuring FL-2s were current. -He was aware the FL-2 for Resident #1 was out of date. -The facility was moving residents to the care of a different PCP due to insurance issues with the current PCP.	C 203		
C 237	10A NCAC 13G .0802 (b) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plan (b) The care plan shall be revised as needed based on further assessments of the resident according to Rule .0801 of this Subchapter This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure a care plan was completed annually for 1 of 3 sampled resident (Resident #1). Review of Resident #1's current FL2 dated	C 237	1. Administrator will ensure Resident Care plan is completed Annually. 2. Administrator has created A log to document completion dates for FL2 and Care Plans. Administrator wants to ensure Care plans and FL2 are completed timely. Vandell Chey Admistrator 8/22/21	

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C 237	Continued From page 7 06/22/20 revealed: -Diagnosis included schizophrenia. -The resident was documented as ambulatory. -There was no information related to orientation status. -The recommended level of care was domiciliary. -There was no other documented diagnosis. Review of Resident #1'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. Interview with the Manager on 07/30/21 at 2:34pm at revealed: -Resident #1 was admitted on 06/22/20 from another facility that had closed. -Resident #1 had no medical problems. -Resident #1 only had mental health issues. -Resident#1 was being followed by behavioral health. -She was responsible for ensuring care plans were current for the residents at the facility. -She was aware Resident #1's care plan was not updated. -She reviewed resident records monthly -The primary care provider (PCP) was refusing to see Resident #1 because they did not have a copy of his insurance card.	C 237	• Administrator will review Records quarterly to ensure care plans ARE completed. • Administrator will review resident orders quarterly to ensure care plans ARE completed. • Completion date 8-2021	

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C 237	Continued From page 8 -The facility was looking for a new PCP but did not have an appointment date. Attempted telephone interview with Resident #1's mental health provider (MHP) on 07/30/21 at 3:05pm was unsuccessful. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 07/30/21 at 3:07pm was unsuccessful. Telephone interview with the Administrator on 07/30/21 at 4:01pm revealed: -Resident #1 had no medical problems. -Resident #1 needed assistance with medication administration but was independent with personal care needs. -The manager was responsible for ensuring care plans were current. -He was aware the care plan for Resident #1 was out of date. -The facility was moving residents to the care of a different PCP due to insurance issues with tho current PCP.	C 237		

Vaughn cfp (Administrator) 8-22-21