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 07/29/2025

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 and follow up survey on 07/29/25.	C 000		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications according to provider orders for 1 of 3 sampled residents (#1) including a medication used to treat mood disorders. The findings are: Review of Resident #1's current FL-2 dated 02/24/25 revealed: -Diagnoses included psychosis, mild intellectual disability, schizophrenia, and gastrointestinal reflux disease. -There was an order for Topiramate 25mg, take one tablet twice a day (Topiramate is used to treat mood disorders). Review of Resident #1's July 2025 medication administration record (MAR) revealed: -There was an entry for Topiramate 25mg, take one tablet twice a day at 8:00am and 8:00pm.	C 330		

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C 330	Continued From page 1 -There was documentation from the facilities contracted pharmacy on the front page of the MAR under the prescription that the resident needed a new prescription to send the medication in batch cycle. -There was a handwritten note by the Supervisor in Charge (SIC) dated 06/25/25 under the typed entry by the pharmacy on the front of the MAR that she spoke with the primary care providers (PCP) nurse to request a refill be sent to the pharmacy. -There was a handwritten note by the SIC on the front of the MAR that the resident's Topiramate arrived at the facility on 07/08/25. -There was no documentation that Topiramate was administered from 07/01/25 to 07/08/25 at 8:00am and 8:00pm. -The space on the MAR where staff should place their initials when the medication was administered was blank. -There was documentation that Topiramate was administered at 8:00am and 8:00pm from 07/09/25 to 07/28/25, and at 8:00am on 07/29/25. Observation of medications on hand on 07/29/25 at 11:30am revealed there were 4 tablets of Topiramate available to administer to Resident #1. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/29/25 at 11:15am revealed: -60 tablets of Topiramate were dispensed to the facility on 05/22/25 for a 30 day supply. -The 60 tablets of Topiramate covered the resident from 06/01/25 to 06/30/25. Second telephone interview with a pharmacist from the facility's contracted pharmacy on 07/29/25 at 11:53am revealed:	C 330		

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C 330	Continued From page 2 -The pharmacy received a new prescription for Topiramate from Resident #1's PCP on 07/08/25. -46 tablets of Topiramate were dispensed to the facility on 07/08/25 for a 23 day supply. Telephone interview with the SIC on 07/29/25 at 1:59pm revealed: -She attempted to reach Resident #1's PCP several times before 07/08/25 and was unsuccessful. -She was able to reach a nurse with the PCP to request a refill on Topiramate for Resident #1 on 07/08/25. -Resident #1 did not have any behavioral issues from 07/01/25 to 07/08/25. -She should have notified Resident #1's PCP when his MARS were delivered to the facility at the end of June 2025. -It was an oversight that she did not catch the typed note from the pharmacist on the July 2025 MARs when they were delivered to the facility. Interview with the Registered Nurse (RN) at the facility on 07/29/25 at 1:53pm revealed: -The SIC should have notified Resident #1's PCP after she received the July MARS since there was a note from the pharmacy on the MARS that a new prescription was needed to fill the resident's Topiramate. -Resident #1 did not have any behavioral issues from 07/01/25 to 07/08/25, however he should have received his medications as prescribed. -She expected the SIC to administer medications as ordered and to notify the resident's PCP when a refill was needed. Attempted telephone interview with Resident #1's PCP on 07/29/25 at 2:08pm was unsuccessful.	C 330		