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
	FCL061008	A. BUILDING: ______ B. WING ______	08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & L FAMILY CARE HOME	842 CANE CREEK ROAD BAKERSVILLE, NC 28705

(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 and the Mitchell County Department of Social Services completed an annual survey on August 23, 2023.	C 000		
C 231	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801Resident Assessment (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 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. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure a care plan was completed within 30 days of admission, which included a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status,	C 231		

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

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C 231	Continued From page 1	C 231		

and physical functioning in activities of daily living (ADL) for 1 of 3 sampled residents (Resident #1) and failed to ensure a care plan was completed annually for 1 of 3 sampled residents (Resident #3).

The findings are:

1. Review of Resident #1's current FL2 dated 05/10/23 revealed:
-Diagnoses included memory loss and high blood pressure.
-Resident #1 was intermittently disoriented.

Review of Resident #1's resident register revealed Resident #1 was admitted to the facility on 05/12/23.

Review of Resident #1's record on 08/22/23 at 10:35am revealed there was no care plan in the record.

Interview with the Administrator on 08/22/23 at 10:50am and 2:35pm revealed:
-She was responsible for completion of all resident paperwork including care plans.
-Resident #1 had come to the facility from a very challenging situation and she had been unable to get all the necessary information to complete a care plan.
-Resident #1 required assistance with meals, medication, and laundry.
-She knew the care plan was supposed to be completed within 30 days of admission, but she "just didn't get to it."

2. Review of Resident #3's FL2 dated 07/07/22 revealed:
-Diagnoses included schizoaffective disorder and major depression.

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C 231	Continued From page 2 -Resident #3 was intermittently disoriented. Review of Resident #3's resident register revealed Resident #3 was admitted to the facility on 07/16/08. Review of Resident #3's record 08/22/23 revealed: -The most recent care plan was dated 07/07/22 and was signed by Resident #3's primary care provider (PCP). -Resident #3 required supervision with eating. -Resident #3 was independent with bathing, dressing, grooming, hygiene, toileting and transfers. Interview with the Administrator on 8/22/23 at 12:30pm and 2:35pm revealed: -She was responsible for completion of all resident paperwork including care plans. -She knew someone had a care plan that was due in July. -She thought she had been taken the care plan for Resident #3 to the doctor's office and dropped the care plan off to be signed. -Resident #3 required assistance with meals, medication, and laundry. -Resident #3 required supervision with eating but was independent for all other ADL's. -Even though not much had changed with Resident #3 in the past year, she should have had a new yearly care plan for him completed timely.	C 231		