10A NCAC 13G .0801 is proposed for readoption with substantive changes as follows:

SECTION .0800 - RESIDENT ASSESSMENT AND CARE PLAN

10A NCAC 13G .0801 RESIDENT ASSESSMENT

~~(a) A family care home shall assure that an initial assessment of each resident is completed within 72 hours of admission using the Resident Register.~~

~~(b)~~(a) The facility shall ~~assure~~ complete an assessment of each resident ~~is completed~~ within 30 days following admission and ~~at least~~ annually ~~thereafter~~ 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, provider of mental health, developmental disabilities or substance abuse services or community resource.~~

(b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed in accordance with Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the 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 instrument established by the Department shall include the following:

(1) resident identification and demographic information;

(2) current diagnoses;

(3) current medications;

(4) the resident's ability to self-administer medications;

(5) the resident's ability to perform activities of daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating;

(6) mental health history;

(7) social history;

(8) mood and behaviors;

(9) nutritional status, including specialized diet or dietary needs;

(10) skin integrity;

(11) memory, orientation and cognition;

(12) vision and hearing;

(13) speech and communication;

(14) assistive devices needed; and

(15) a list of and contact information for health care providers or services used by the resident.

The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms/dma-3050r-adult-care-home-personal-care-physician/@@display-file/form_file/dma-3050R.pdf.pdf at no cost.

(c) When a facility identifies a change in a resident's baseline condition based upon the factors listed in Part (1)(A) through (M) of this Paragraph, the facility shall monitor the resident's condition for no more than 10 days to determine if a significant change in the resident's condition has occurred. For the purposes of this rule, "significant change" means a major decline or improvement in a resident's status related to factor in Part (1)(A) through (M) of this Paragraph. The facility shall ~~assure~~ conduct an assessment of a resident is completed within ~~10~~ three days ~~following~~ after the facility identifies that a significant change in the resident's baseline condition has occurred. The facility shall use ~~using~~ the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows:

(1) Significant change is one or more of the following:

(A) deterioration in two or more activities of daily ~~living;~~ living including bathing, dressing, personal hygiene, toileting, or eating;

(B) change in ability to walk or ~~transfer;~~ transfer, including falls if the resident experiences repeated falls on the same day, recurrent falls overall several days to weeks, new onset of falls not attributed to a readily identifiable cause, or a fall with consequent change in neurological status, or findings suggesting a possible injury;

(C) ~~change in the ability to use one's hands to grasp small objects;~~ Pain worsening in severity, intensity, or duration, and/or occurring in a new location, or new onset of pain associated with trauma;

(D) ~~deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic;~~ change in the pattern of usual behavior, new onset of resistance to care, abrupt onset or progression of significant agitation or combative behavior, deterioration in affect or mood, or violent or destructive behaviors directed at self or others.

(E) no response by the resident to the ~~treatment~~ intervention for an identified problem;

(F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period;

(G) ~~threat to life such as stroke, heart condition, or metastatic cancer;~~ when a resident has been enrolled in hospice;

(H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or ~~higher;~~ any pressure ulcer determined to be greater than Stage II;

(I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being; ~~well-being such as initial diagnosis of Alzheimer's disease or diabetes;~~

(J) improved behavior, mood or functional health status to the extent that the established plan of care no longer meets the resident's needs; ~~matches what is needed;~~

(K) new onset of impaired decision-making;

(L) continence to incontinence or indwelling catheter; or

(M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident.

(2) Significant change ~~is not any of~~ does not include the following:

(A) changes that suggest slight upward or downward movement in the resident's status;

(B) changes that resolve with or without intervention;

(C) changes that arise from easily reversible causes;

(D) an acute illness or episodic ~~event;~~ event. For the purposes of this Rule "acute illness" means symptoms or a condition that develops quickly and is not a part of the resident's baseline physical health or mental health status;

(E) an established, predictive, cyclical pattern; or

(F) steady improvement under the current course of care.

(d) If a resident experiences a significant change as defined in Paragraph (c) of this Rule, the facility shall refer the resident to the resident's physician or other ~~appropriate~~ licensed health professional ~~such as a mental health professional, nurse practitioner, physician assistant or registered nurse in a timely manner consistent with the resident's condition but~~ no longer than ~~10~~ three days from the date of the significant ~~change,~~ change assessment, and document the referral in the resident's record. Referral shall be made immediately when significant changes are identified that pose an immediate risk to the health and safety of the resident, other ~~residents~~ residents, or staff of the facility.

(e) The assessments required in Paragraphs (a) ~~(b)~~ and (c) of this Rule shall be completed and signed by the person designated by the administrator to perform resident assessments.

History Note: *Authority G.S. 131D-2.16; 131D-4.4; 131D-4.5; 143B-165;*
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