10A NCAC 13G .0802 RESIDENT CARE PLAN

(a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan.

(b) The resident shall be offered the opportunity to participate in the development of his or her care plan. If the resident is unable to participate in the development of the care plan due to cognitive impairment, the responsible person as defined in Rule .0102 of this Subchapter shall be offered the opportunity to participate in the development of the care plan.

(c) The care plan shall include the following:

(1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section;

(2) frequency of the services or tasks to be performed;

(3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section;

(4) licensed health professional tasks required according to Rule .0903 of this Section;

(5) a dated signature of the assessor upon completion; and

(6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid.

(d) If the resident received home health or hospice services, the facility shall communicate with the home health or hospice agency to coordinate care and services to ensure the resident's needs are met.

(e) The facility shall assure that the care plan for each resident who is under the care of a provider of mental health, developmental disabilities or substance use services includes instructions regarding how to contact that provider, including emergency and after-hours contacts. Whenever significant behavioral changes described in Rule .0801(c)(1)(D) of this Subchapter are identified, the facility shall refer the resident to a provider of mental health, developmental disabilities or substance use services in accordance with Rule .0801(d) of this Subchapter.

(f) The care plan shall be revised as needed based on the results of a significant change assessment completed in accordance with Rule .0801 of this Section.

History Note: *Authority G.S. 131D-2.15; 131D-2.16; 131D-4.3; 131D-4.4; 131D-4.5; 143B-165;*
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