

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051-095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/29/2025
NAME OF PROVIDER OR SUPPLIER ASSURANCE FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 81 UNION CITY CT CLAYTON, NC 27520		
(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 initial survey on July 29, 2025.	C 000		
C 236	10A NCAC 13G .0802 (a) (c) Resident Care Plan 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. (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	C 236		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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C 236	Continued From page 1 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. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 1 of 3 sampled residents (#1) had a dated signature of the resident's primary care provider (PCP) within 15 days of completion of the care plans. The findings are: 1. Review of Resident #1's current FL-2 dated 01/17/25 revealed: -Diagnoses included dementia, hypertension, chronic kidney disease, unsteady gait, paroxysmal atrial fibrillation, and benign prostatic hyperplasia. -Resident #1 was constantly disoriented, semi ambulatory, incontinent of bladder at times, and continent of bowels. -Resident #1 required personal care assistance with bathing and dressing. Review of Resident #1's Resident Register revealed the resident's admission date was 01/23/25. Review of Resident #1's care plan dated 01/23/25 revealed: -The care plan assessment date was 01/23/25.	C 236		

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C 236	Continued From page 2 -The care plan reassessment date was 04/23/25. -The care plan was signed by the Registered Nurse (RN) on 01/23/25. -The care plan was not signed by the primary care provider (PCP). -Resident #1 required extensive assistance with bathing, dressing, grooming, and toileting. -He required minimal assistance with ambulation and transferring and he was independent with eating. Observation of Resident #1 on 07/29/25 at 10:00am revealed: -Resident #1 was sitting in a wheelchair at the activities table. -Resident #1 was coloring and listening to music. Interview with the Administrator on 07/29/25 at 2:00pm revealed: -She was not aware Resident #1's care plan was not signed by the PCP. -She and the MA did not follow up with the PCP after faxing the care plan to their office. Interview with the medication aide (MA) on 07/29/25 at 1:40pm revealed: -He was not aware Resident #1 care plans were not signed by the PCP. -He was responsible to gather all the paperwork and notifying the PCP about the care plans. -He was aware that the PCP should have signed within 15 days of creating Resident #1's care plan. -It was an oversight that the care plans were not signed by the PCP. -He was in the process of creating a system to audit the charts to ensure all paperwork had been completed. Interview with the Administrator on 07/29/25 at	C 236		

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C 236	Continued From page 3 2:15pm revealed: -She and the MA were responsible to ensure the care plans are completed. -She was aware that the PCP should have signed within 15 days of creating Resident #1's care plan. -She and the MA were in the process of creating a checklist to ensure all paperwork was up to date. Based on observations, interviews, and record reviews it was determined that Resident #1 was not interviewable.	C 236		