

1 10A NCAC 13D .2301 is proposed for readoption as follows:
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3 **SECTION .2300 – PATIENT AND RESIDENT CARE AND SERVICES**
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5 **10A NCAC 13D .2301 PATIENT ASSESSMENT AND PLAN OF CARE**

6 (a) At the time each patient is admitted, the facility shall ensure medical orders are available for the patient's
7 immediate care and that, within 24 hours, a nursing assessment of immediate needs is completed by a registered nurse
8 and measures implemented as appropriate.

9 (b) The facility shall perform, within 14 days of admission and at least annually, a comprehensive, accurate,
10 documented assessment of each patient's capability to perform daily life functions. This comprehensive assessment
11 shall be coordinated by a registered nurse and shall include at least the following:

- 12 (1) current medical diagnoses;
- 13 (2) medical status measurements, including current cognitive status, stability of current conditions and
14 diseases, vital signs, and abnormal lab values and diagnostic tests that are a part of the medical
15 history;
- 16 (3) the patient's ability to perform activities of daily living, including the need for staff assistance and
17 assistive devices, and the patient's ability to make decisions;
- 18 (4) presence of neurological or muscular deficits;
- 19 (5) nutritional status measurements and requirements, including but not limited to height, weight, lab
20 work, eating habits and preferences, and any dietary restrictions;
- 21 (6) special care needs, including but not limited to pressure sores, enteral feedings, specialized
22 rehabilitation services or respiratory care;
- 23 (7) indicators of special needs related to patient behavior or mood, interpersonal relationships and other
24 psychosocial needs;
- 25 (8) facility's expectation of discharging the patient within the three months following admission;
- 26 (9) condition of teeth and gums, and need and use of dentures or other dental appliances;
- 27 (10) patient's ability and desire to take part in activities, including an assessment of the patient's normal
28 routine and lifetime preferences;
- 29 (11) patient's ability to improve in functional abilities through restorative care;
- 30 (12) presence of visual, hearing or other sensory deficits; and
- 31 (13) drug therapy.

32 (c) The facility shall develop a comprehensive plan of care for each patient and shall include measurable objectives
33 and timetables to meet needs identified in the comprehensive assessment. The facility shall ensure the comprehensive
34 plan of care is developed within seven days of completion of the comprehensive assessment by an interdisciplinary
35 team. To the extent practicable, preparation of the comprehensive plan of care shall include the participation of the
36 patient and the patient's family or legal representative. The physician may participate by alternative methods,
37 including, but not limited to, telephone or face-to-face discussion, or written notice.

1 (d) The facility shall review comprehensive assessments and plans of care no less frequently than once every 90 days
2 and make necessary revisions to ensure accuracy.

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4 *History Note: Authority G.S. 131E-104; 131E-116;*

5 *RRC objection due to lack of statutory authority Eff. July 13, 1995;*

6 *Eff. January 1, 1996;*

7 *Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22,*

8 *2015-2015;*

9 *Readopted Eff. August 1, 2026.*