REQUEST FOR CHANGES PURSUANT TO G.S. 150B-21.10

AGENCY: N.C. Medical Care Commission

RULE CITATION: 10A NCAC 13F .0703

DEADLINE FOR RECEIPT: December 8, 2023

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may email the reviewing attorney to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following changes be made:

Page 2, Line 2: While it is implied that form FL-2 consists of Paragraph (e)(1)-(7), it is not clear. Does FL-2 consist solely of the items required in Paragraph (e)(1)-(7)? If so, Page 2, Line 2 should read, "The FL-2 and the medical examination shall consist of…"

Page 2, Line 33: G.S. 13D-9 does not exist.

Page 2, Lines 32-33: If G.S. 131D-9 requires immunization, why is Paragraph (i) necessary?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

William W. Peaslee
Commission Counsel
Date submitted to agency: November 28, 2023

10A NCAC 13F .0703 is readopted as published in 37:24 NCR 2219-2227 as follows:

10A NCAC 13F .0703 TUBERCULOSIS TEST, MEDICAL EXAMINATION AND IMMUNIZATIONS

(a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. ~~Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.~~

(b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the facility and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident.

(c) ~~The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following:~~

~~(1) The examining date recorded on the FL-2 or MR-2 shall be no more than 90 days prior to the person's admission to the home.~~

~~(2) The FL-2 or MR-2 shall be in the facility before admission or accompany the resident upon admission and be reviewed by the facility before admission except for emergency admissions.~~

~~(3) In the case of an emergency admission, the medical examination and completion of the FL-2 or MR-2 as required by this rule shall be within 72 hours of admission as long as current medication and treatment orders are available upon admission or there has been an emergency medical evaluation, including any orders for medications and treatments, upon admission.~~

~~(4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the facility shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs.~~

~~(5) The completed FL-2 or MR-2 shall be filed in the resident's record in the home.~~

~~(6) If a resident has been hospitalized, the facility shall have a completed FL-2 or MR-2 or a transfer form or discharge summary with signed prescribing practitioner orders upon the resident's return to the facility from the hospital.~~

The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission.

(d) In the case of an unplanned, emergency admission, the medical examination of the resident shall be conducted within 72 hours after admission. Prior to an emergency admission, the facility shall obtain current medication and treatment orders from a licensed physician or physician extender.

(e) The result of the medical examination required in Paragraph (b) of this Rule shall be documented on the North Carolina Medicaid Adult Care Home FL-2 form which is available at no cost on the Department's Medicaid website

at https://medicaid.ncdhhs.gov/media/6549/open. The Adult Care Home FL-2 shall be signed and dated by the physician or physician extender completing the medical examination. The medical examination shall include the following:

(1) resident's identification information, including the resident's name, date of birth, sex, admission date, county and Medicaid number, current facility and address, physician's name and address, a relative's name and address, current level of care, and recommended level of care;

(2) resident's admitting diagnoses, including primary and secondary diagnoses and dates of onset;

(3) resident's current medical information, including orientation, behaviors, personal care assistance needs, frequency of physician visits, ambulatory status, functional limitations, information related to activities and social needs, neurological status, bowel and bladder functioning status, manner of communication of needs, skin condition, respiratory status, and nutritional status including orders for therapeutic diets;

(4) special care factors, including physician orders for blood pressure, diabetic urine testing, physical therapy, range of motion exercises, a bowel and bladder program, a restorative feeding program, speech therapy, and restraints;

(5) resident's medications, including the name, strength, dosage, frequency and route of administration of each medication;

(6) results of x-rays or laboratory tests determined by the physician or physician extender to be necessary information related to the resident's care needs; and

(7) additional information as determined by the physician or physician extender to be necessary for the care of the resident.

(f) If the information on the Adult Care Home FL-2 is not clear or is insufficient, or information provided to the facility related to the resident's condition or medications after the completion of the medical examination conflicts with the information provided on the Adult Care Home FL-2, the facility shall contact the physician or physician extender for clarification in order to determine if the facility can meet the individual's needs.

(g) The results of the medical examination shall be maintained in the resident's record in accordance with Rule .1201 of this Subchapter. Discharge medication orders shall be clarified in accordance with Rule .1002(a) of this Subchapter.

(h) Upon a resident's return to the facility from a hospitalization, the facility shall obtain and review the hospital discharge summary or discharge instructions, including any discharge medication orders. If the facility identifies discrepancies between the discharge orders and current orders at the facility, the facility shall clarify the discrepancies with the resident's physician or physician extender.

~~(d)~~(i) Each resident shall be immunized against pneumococcal disease and annually against influenza virus according to G.S. 13D-9, except as otherwise indicated in ~~this~~ law.

~~(e)The facility shall make arrangements for any resident, who has been an inpatient of a psychiatric facility within 12 months before entering the home and who does not have a current plan for psychiatric care, to be examined by a local physician or a physician in a mental health center within 30 days after admission and to have a plan for psychiatric follow-up care when indicated.~~

(j) The facility shall make arrangements for a resident to be evaluated by a licensed mental health professional, licensed physician or licensed physician extender for follow-up psychiatric care within 30 days of admission or re-admission to the facility when the resident:

(1) has been an inpatient of a psychiatric facility within 12 months prior to admission to the facility and does not have a current plan for follow-up psychiatric care; or

(2) has been hospitalized due to threatening or violent behavior, suicidal ideation or self-harm, or other psychiatric symptoms that required hospitalization within 12 months prior to admission to the facility and does not have a current plan for follow-up psychiatric care.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Temporary Adoption Eff. September 1, 2003;
Eff. June 1, ~~2004.~~ 2004;
Readopted Eff. January 1, 2024.

REQUEST FOR CHANGES PURSUANT TO G.S. 150B-21.10

AGENCY: N.C. Medical Care Commission

RULE CITATION: 10 NCAC 13F .0704

DEADLINE FOR RECEIPT: December 8, 2023

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may email the reviewing attorney to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following changes be made:

Page 1, Line 11: Change "include" to "consist of".

Page 1, Lines 33-35: Explain why this "note" is necessary? The language is permissive in nature without any restriction prohibiting the activity. Why wouldn't facilities be able to accept payments from a third party?

Page 2, Line 17: Change "include" to "consist of".

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

William W. Peaslee
Commission Counsel
Date submitted to agency: November 28, 2023

10A NCAC 13F .0704 is readopted as published in 37:24 NCR 2219-2227 as follows:

10A NCAC 13F .0704 RESIDENT CONTRACT, INFORMATION ON ~~HOME~~ FACILITY, AND RESIDENT REGISTER

(a) An adult care home administrator or ~~administrator in charge~~ or their management designee shall furnish and review with the resident or ~~responsible person~~ the resident's authorized representative as defined in Rule .1103 of this Subchapter information on the ~~home~~ facility upon admission and when changes are made to that information. The facility shall involve the resident in the review of the resident contract and information on the facility unless the resident is cognitively unable to participate in the discussion. A statement indicating that this information has been received upon admission or amendment as required by this Rule shall be signed and dated by each person to whom it is given and retained in the resident's record in the ~~home~~ facility. The information shall include the following:

(1) the resident contract to which the following applies:

(A) the contract shall specify ~~rates~~ charges for resident services and accommodations, including the cost of different levels of service, ~~if applicable,~~ description of levels of care and services, and any other charges or fees;

(B) the contract shall disclose any health needs or conditions that the facility has determined it cannot ~~meet pursuant to G.S. 131D-2(a1)(4);~~ meet;

(C) the contract shall be signed and dated by the administrator or ~~administrator in charge~~ management designee and the resident or ~~responsible person,~~ the resident's authorized representative, a copy given to the resident or ~~responsible person~~ the resident's authorized representative and a copy kept in the resident's record;

(D) the resident or ~~responsible person~~ the resident's authorized representative shall be ~~notified as soon as any change is known, but not less than 30 days before the change for rate changes initiated by the facility, of any changes in the contract~~ given a written 30-day notice prior to any change in charges for resident services and accommodations, including the cost of different levels of service, description of level of care and services, and any other charges or fees, and be provided an amended contract or an amendment to the contract for review and ~~signature;~~ confirmation of receipt;

(E) gratuities in addition to the established rates shall not be accepted; and

(F) the maximum monthly adult care home rate that may be charged to Special Assistance recipients ~~is~~ as established by the North Carolina Social Services Commission and the North Carolina General Assembly.

Note: Facilities may accept payments for room and board from a third party, such as family member, charity or faith community, if the payment is made voluntarily to supplement the cost of room and board for the added benefit of a private room or a private or semi-private room in a special care unit.

(2) a written copy of all house rules, including facility policies on smoking, alcohol consumption, visitation, refunds and the requirements for discharge of residents consistent with the rules of this

Subchapter, and amendments disclosing any changes in the house ~~rules;~~ rules. The house rules shall be in compliance with G.S. 131D-21;

(3) a copy of the Declaration of Residents' Rights as found in G.S. 131D-21;

(4) a copy of the ~~home's~~ facility's grievance procedures ~~which~~ that shall indicate how the resident is to present complaints and make suggestions as to the ~~home's~~ facility's policies and services on behalf of himself or herself or others; and

(5) a statement as to whether the ~~home~~ facility has signed Form DSS-1464, Statement of Assurance of Compliance with Title VI of the Civil Rights Act of 1964 for Other Agencies, Institutions, Organizations or Facilities, and which shall also indicate that, if the ~~home~~ facility does not choose to comply or is ~~found to be in non-compliance,~~ non-compliant, the residents of the ~~home~~ facility would not be able to receive State-County Special Assistance for Adults and the ~~home~~ facility would not receive supportive services from the county department of social services.

(b) The administrator or ~~administrator in charge~~ their management designee and the resident or the resident's ~~responsible person~~ representative shall complete and sign the Resident Register initial assessment within 72 hours of the resident's admission to the facility ~~and revise the information on the form as needed.~~ in accordance with G.S. 131D-2.15. The facility shall involve the resident in the completion of the Resident Register unless the resident is cognitively unable to participate. The Resident Register shall include the following:

(1) resident's identification information including the resident's name, date of birth, sex, admission date, medical insurance, family and emergency contacts, advanced directives, and physician's name and address;

(2) resident's current care needs including activities of daily living and services, use of assistive aids, orientation status;

(3) resident's preferences including personal habits, food preferences and allergies, community involvement, and activity interests;

(4) resident's consent and request for assistance including the release of information, personal funds management, personal lockable space, discharge information, and assistance with personal mail;

(5) name of the individual identified by the resident who is to receive a copy of the notice of discharge per G.S. 131D-4.8; and

(6) resident's consent including a signature confirming the review and receipt of information contained in the form.

The Resident Register is available on the internet website, https://info.ncdhhs.gov/dhsr/acls/pdf/resregister.pdf ~~or~~ at no ~~charge from the Division of Health Service Regulation, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708.~~ charge. The facility may use a resident information form other than the Resident Register as long as it contains ~~at least~~ the same information as the Resident Register. Information on the Resident Register shall be kept updated and maintained in the resident's record.

History Note: *Authority 131D-2.15; 131D-2.16; 143B-165;*

Temporary Adoption Eff. July 1, 2004;
Eff. July 1, 2005.
Amended Eff. April 1, ~~2022.~~ 2022;
Readopted Eff. January 1, 2024.

REQUEST FOR CHANGES PURSUANT TO G.S. 150B-21.10

AGENCY: N.C. Medical Care Commission

RULE CITATION: 10 NCAC 13F .1103

DEADLINE FOR RECEIPT: December 8, 2023

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may email the reviewing attorney to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following changes be made:

Page 1, Line 4: Who determines when the resident is "unable to manage" their finances?

Page 1, Line 5: What happens if the resident has stated, either in writing or verbally, that the resident's family is not to be notified? What if the resident has designated a non-family member as the point of contact or has an attorney-in-fact designated?

Page 1, Lines 7-8: As written, an incompetent resident could sign the written authorization. Was that the Commission's intention?

Page 1, Lines 8-9: This line seems like it should be part of Paragraph (b).

Page 1, Line 13: The administrator is required to give the payee of any monies receipts? Please explain.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

William W. Peaslee
Commission Counsel
Date submitted to agency: November 28, 2023

10A NCAC 13F .1103 is amended as published in 37:24 NCR 2219-2227 as follows:

10A NCAC 13F .1103 ~~LEGAL~~ AUTHORIZED REPRESENTATIVE ~~OR PAYEE~~

(a) In situations where a resident of an adult care home is unable to manage ~~his~~ their monetary funds, the administrator shall contact a family member or the county department of social services regarding the need for ~~a legal representative or payee.~~ an authorized representative. For the purposes of this Rule, an "authorized representative" shall mean a person who is legally authorized or designated in writing by the resident to act on his or her behalf in the management of their funds. The administrator and other staff of the ~~home~~ facility shall not serve as a resident's ~~legal~~ authorized representative, payee, or executor of a will, except as indicated in Paragraph (b) of this Rule.

(b) In the case of funds administered by the Social Security Administration, the Veteran's Administration or other federal government agencies, the administrator of the ~~home~~ facility may serve as a payee when so authorized as a legally constituted authority by the respective federal agencies.

(c) The administrator shall give the resident's ~~legal~~ authorized representative or payee receipts for any monies received on behalf of the resident.

History Note: *Authority G.S. 35A-1203; 108A-37; 131D-2.16; 143B-165;*
Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~2018.~~ 2018;
Amended Eff. January 1, 2024.

REQUEST FOR CHANGES PURSUANT TO G.S. 150B-21.10

AGENCY: N.C. Medical Care Commission

RULE CITATION: 10 NCAC 13F .1104

DEADLINE FOR RECEIPT: December 8, 2023

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may email the reviewing attorney to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following changes be made:

Page 1, Lines 7, 10, 13: Define "authorized representative".

Page 1, Lines 10-14: The language is permissive in nature and their does not appear to be an restriction which would prohibit the activity.

Consider, "No employee of a facility shall handle a resident's monies, except for the facility administrator or the administrator's designee after having received prior written authorization from the resident or the resident's lawful representative. The facility shall maintain an accurate account balance and accounting of all receipts and disbursements, which shall be available upon request to the resident or their lawful representative during the facility's regular business office hours.

Page 1, Lines 15-21: Here the Commission uses the term "personal funds" but Paragraph (b) states "personal monies". Unless the Commission is addressing different things, be consistent with the terms.

Page 1, Lines 15-21: As written, the resident must verify the accuracy of the "disbursement of personal funds" but the authorized representative is only verifying receipt of the record. Is that what the Commission intended?

Page 1, Lines 15-21: The passive voice is used. Consider, "The facility shall provide each resident or the resident's lawful representative a written monthly accounting of the resident's monies handled by the administrator or the administrator's designee. The facility shall maintain at the facility a record signed by the resident or their lawful representative indicating whether the resident or their lawful representative agree that the monthly accounting is accurate.

Page 1, Lines 15-21: How long must the records be maintained?

William W. Peaslee
Commission Counsel
Date submitted to agency: November 28, 2023

Page 1, Lines 22-23: As written, the facility can commingle a resident's funds with other residents' funds so long as it is a non-interest baring account. Is that correct? The facility can hold a resident's funds in an interest baring account so long as no other resident's funds are in that account. Is that correct? Who gets the interest?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

William W. Peaslee
Commission Counsel
Date submitted to agency: November 28, 2023

10A NCAC 13F .1104 is amended as published in 37:24 NCR 2219-2227 as follows:

10A NCAC 13F .1104 ACCOUNTING FOR RESIDENT'S PERSONAL FUNDS

(a) To document a resident's receipt of the State-County Special Assistance personal needs allowance after payment of the cost of care, a statement shall be signed by the resident or marked by the ~~resident with two witnesses' signatures.~~ resident. If the statement is marked by the resident, there shall be one witness signature. For residents who have been adjudicated incompetent, the signature of the resident's authorized representative shall be required. Witnesses cannot include the staff handling the residents' personal funds transactions. The statement shall be maintained in the ~~home.~~ facility.

(b) Upon the written authorization of the resident or ~~his legal representative or payee,~~ their authorized representative, an ~~administrator~~ administrator, or the administrator's designee may handle the personal money for a resident, provided an accurate accounting of monies received and disbursed and the balance on hand is available upon request of the resident or ~~his legal representative or payee.~~ their authorized representative during the facility's established business days and hours.

(c) A record of each transaction involving the use of the resident's personal funds according to Paragraph (b) of this Rule shall be signed by the ~~resident, legal~~ resident of the resident's authorized representative ~~or payee~~ or marked by the ~~resident, if not adjudicated incompetent, with two witnesses' signatures~~ resident at least monthly verifying the accuracy of the disbursement of personal funds. If marked by the resident, there shall be one witness signature. For residents who have been adjudicated incompetent, the facility shall provide the resident's authorized representative with a copy of the monthly resident's funds statement and shall obtain verification of receipt. The ~~record~~ records shall be maintained in the ~~home.~~ facility.

(d) A resident's personal funds shall not be commingled with facility funds. The facility shall not commingle the personal funds of residents in an interest-bearing account.

(e) All or any portion of a resident's personal funds shall be available to the resident or ~~his legal representative or payee~~ their authorized representative upon request during ~~regular office hours,~~ the facility's established business days and hours except as provided in Rule .1105 of this ~~Subchapter.~~ Section.

(f) The resident's personal needs allowance shall be credited to the ~~resident~~" resident's account within ~~24 hours of the check being deposited following endorsement.~~ one business day of the funds being available in the facility's resident personal funds account.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~2018.~~ 2018;
Amended Eff. January 1, 2024.

REQUEST FOR CHANGES PURSUANT TO G.S. 150B-21.10

AGENCY: N.C. Medical Care Commission

RULE CITATION: 10 NCAC 13F .1106

DEADLINE FOR RECEIPT: December 8, 2023

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may email the reviewing attorney to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following changes be made:

Generally, to the rule: It appears that the Commission is attempting to regulate contractual obligations between the facilities and residents. It does not appear that the Commission has authority over residents, or at least not a viable enforcement mechanism. The Commission

Page 1, Line 4-6: This is grammatically incorrect. Consider changing.

Page 1, Lines 11-13: Explain the Commission's authority over former residents or to determine or adjudicate the contractual obligations of a former resident. Also, explain how this will be enforced. What will the Commission or department do in the event of non-payment?

Page 1, Lines 11-12: It is unclear whether moving out pursuant to .0702(i) is an example of a resident moving out without giving notice, or whether the paragraph applies in this exclusive circumstance. It can be read two ways.

Page 1, Lines 13-15: "Entitled" from whom?

Page 1, Lines 13-15: Explain the Commission's authority over former residents or to determine or adjudicate the contractual obligations of a former resident.

Page 1, Lines 18-20: Explain the Commission's authority over former residents or to determine or adjudicate the contractual obligations of a former resident.

Page 1, Line 18: If it meets the intention of the Commission, remove the comma after "notice". If it does not meet the Commission's intention, explain why.

Page 1, Line 22-23: Rule .0702(i) does not require notice. It is unclear what the Commission intends by the inclusion of the reference.

William W. Peaslee
Commission Counsel
Date submitted to agency: November 28, 2023

Page 1, Lines 26-37, and Page 2, Lines 1-12: Paragraph (e) is poorly written and is confusing. It should be re-written.

Line 26: Who determines the intent?

Page 1, Lines 27 and 31: The Commission is using permissive language when there does not appear to be a restriction. Put another way, in the absence of a restriction, the parties to an agreement can agree as they will.

Page 1, Lines 33-35: I think the Commission is attempting to prohibit facilities from enforcing any notice requirements unless those requirements are explained the resident or their lawful representative, provided in writing and signed by the resident or their lawful representative. However, it is unclear.

Page 2, Line 4: Change "may" to "shall". This would be clearer and more concise if put in the active voice.

Page 2, Lines 13-15: A refund shall be given by whom? This would be clearer and more concise if put in the active voice. "The adult day care facility shall provide a refund of…. "

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

William W. Peaslee
Commission Counsel
Date submitted to agency: November 28, 2023

10A NCAC 13F .1106 is readopted as published in 37:24 NCR 2219-2227 as follows:

10A NCAC 13F .1106 SETTLEMENT OF COST OF CARE

(a) If a resident of an adult care home, after being notified by the facility of its intent to discharge the resident in accordance with Rule .0702 of this Subchapter, ~~moves out of the facility before the period of time specified in the notice has elapsed,~~ the facility shall refund the resident an amount equal to the cost of care for the remainder of the month minus any nights spent in the facility during the notice period. The refund shall be made within 14 days after the resident leaves the facility. For the purposes of this Rule, "cost of care" means any monies paid by the resident or the resident's legal representative in advance for room and board and services provided by the facility as agreed upon in the resident's contract.

(b) If a resident moves out of the facility without giving notice, as may be required by the facility according to Rule ~~.0702(h)~~ .0702(i) of this Subchapter, or before the facility's required notice period has elapsed, the resident owes the facility an amount equal to the cost of care for the required notice period. If a resident receiving State-County Special Assistance moves before the facility's required notice period has elapsed, the former facility is entitled to the required payment for the notice period before the new facility receives any payment. The facility shall refund the resident the remainder of any advance payment following settlement of the cost of care. The refund shall be made within 14 days from the date of notice or, if no notice is given, within 14 days after the resident leaves the facility.

(c) When there is an exception to the notice, as provided in Rule ~~.0702(h)~~ .0702(i) of this Subchapter, to protect the health or safety of the resident or others in the facility, or when there is a sudden, unexpected closure of the facility that requires the resident to relocate, the resident is only required to pay for any nights spent in the facility. A refund shall be made to the resident by the facility within 14 days from the date of notice.

(d) When a resident gives notice of leaving the facility, as may be required by the facility according to Rule ~~.0702(h)~~ .0702(i) of this Subchapter, and leaves at the end of the notice period, the facility shall refund the resident the remainder of any advance payment within 14 days from the date of notice. If notice is not required by the facility, the refund shall be made within 14 days after the resident leaves the facility.

(e) When a resident leaves the facility with the intent of returning to it, the following apply:

(1) The facility may reserve the resident's bed for a set number of days with the written agreement of the facility and the resident or his or her responsible person and thereby require payment for the days the bed is held.

(2) If, after leaving the facility, the resident decides not to return to it, the resident or someone acting on his or her behalf may be required by the facility to provide up to a 14-day written notice that he is not returning.

(3) Requirement of a notice, if it is to be applied by the facility, shall be a part of the written agreement and explained by the facility to the resident and his or her family or responsible person before signing.

(4) On notice by the resident or someone acting on his or her behalf that he will not be returning to the facility, the facility shall refund the remainder of any advance payment to the resident or his or her

responsible person, minus an amount equal to the cost of care for the period covered by the agreement. The refund shall be made within 14 days after notification that the resident will not be returning to the facility.

(5) In no situation involving a recipient of State-County Special Assistance may a facility require payment for more than 30 days since State-County Special Assistance is not authorized unless the resident is actually residing in the facility or it is anticipated that he or she will return to the facility within 30 days.

(6) Exceptions to the ~~two weeks'~~ 14-day notice, if required by the facility, are cases where returning to the facility would jeopardize the health or safety of the resident or others in the facility as certified by the resident's physician or approved by the county department of social services, and in the case of the resident's death. In these cases, the facility shall refund the rest of any advance payment calculated beginning with the day the facility is notified.

(f) If a resident dies, the administrator of his estate or the Clerk of Superior Court, when no administrator for his or her estate has been appointed, shall be given a refund equal to the cost of care for the month minus any nights spent in the facility during the month. This is to be done within 30 days after the resident's death.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. January 1, 2024.

REQUEST FOR CHANGES PURSUANT TO G.S. 150B-21.10

AGENCY: N.C. Medical Care Commission

RULE CITATION: 10A NCAC 13G .0702

DEADLINE FOR RECEIPT: December 8, 2023

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may email the reviewing attorney to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following changes be made:

Page 2, Line 2: While it is implied that form FL-2 consists of Paragraph (e)(1)-(7), it is not clear. Does FL-2 consist solely of the items required in Paragraph (e)(1)-(7)? If so, Page 2, Line 2 should read, "The FL-2 and the medical examination shall consist of…"

Page 2, Lines 34-35: If G.S. 131D-9 requires immunization, why is Paragraph (i) necessary?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

William W. Peaslee
Commission Counsel
Date submitted to agency: November 28, 2023

10A NCAC 13G .0702 is readopted as published in 37:24 NCR 2219-2227 as follows:

10A NCAC 13G .0702 TUBERCULOSIS TEST AND MEDICAL ~~EXAMINATION~~ EXAMINATION, AND IMMUNIZATIONS

(a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. ~~Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.~~

(b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the home and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident.

(c) ~~The results of the complete examination are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following:~~

~~(1) The examining date recorded on the FL-2 or MR-2 shall be no more than 90 days prior to the person's admission to the home.~~

~~(2) The FL-2 or MR-2 shall be in the facility before admission or accompany the resident upon admission and be reviewed by the administrator or supervisor-in-charge before admission except for emergency admissions.~~

~~(3) In the case of an emergency admission, the medical examination and completion of the FL-2 or MR-2 shall be within 72 hours of admission as long as current medication and treatment orders are available upon admission or there has been an emergency medical evaluation, including any orders for medications and treatments, upon admission.~~

~~(4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the administrator or supervisor-in-charge shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs.~~

~~(5) The completed FL-2 or MR-2 shall be filed in the resident's record in the home.~~

~~(6) If a resident has been hospitalized, the facility shall have a completed FL-2 or MR-2 or a transfer form or discharge summary with signed prescribing practitioner orders upon the resident's return to the facility from the hospital.~~

The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission.

(d) In the case of an unplanned, emergency admission, the medical examination of the resident shall be conducted within 72 hours after admission. Prior to an emergency admission, the facility shall obtain current medication and treatment orders from a licensed physician or physician extender.

(e) The result of the medical examination required in Paragraph (b) of this Rule shall be documented on the North Carolina Medicaid Adult Care Home FL-2 form which is available at no cost on the Department's Medicaid website at https://medicaid.ncdhhs.gov/media/6549/open. The Adult Care Home FL-2 shall be signed and dated by the physician or physician extender completing the medical examination. The medical examination shall include the following:

(1) resident's identification information, including the resident's name, date of birth, sex, admission date, county and Medicaid number, current facility and address, physician's name and address, a relative's name and address, current level of care, and recommended level of care;

(2) resident's admitting diagnoses, including primary and secondary diagnoses and dates of onset;

(3) resident's current medical information, including orientation, behaviors, personal care assistance needs, frequency of physician visits, ambulatory status, functional limitations, information related to activities and social needs, neurological status, bowel and bladder functioning status, manner of communication of needs, skin condition, respiratory status, and nutritional status including orders for therapeutic diets;

(4) special care factors, including physician orders for blood pressure, diabetic urine testing, physical therapy, range of motion exercises, a bowel and bladder program, a restorative feeding program, speech therapy, and restraints;

(5) resident's medications, including the name, strength, dosage, frequency and route of administration of each medication;

(6) results of x-rays or laboratory tests determined by the physician or physician extender to be necessary information related to the resident's care needs; and

(7) additional information as determined by the physician or physician extender to be necessary for the care of the resident.

(f) If the information on the Adult Care Home FL-2 is not clear or is insufficient, or information provided to the facility related to the resident's condition or medications after the completion of the medical examination conflicts with the information provided on the Adult Care Home FL-2, the facility shall contact the physician or physician extender for clarification in order to determine if the facility can meet the individual's needs.

(g) The results of the medical examination shall be maintained in the resident's record in accordance with Rule .1201 of this Subchapter. Discharge medication orders shall be clarified in accordance with Rule .1002(a) of this Subchapter.

(h) Upon a resident's return to the facility from a hospitalization, the facility shall obtain and review the hospital discharge summary or discharge instructions, including any discharge medication orders. If the facility identifies discrepancies between the discharge orders and current orders at the facility, the facility shall clarify the discrepancies with the resident's physician or physician extender.

~~(d)~~(i) Each resident shall be immunized against pneumococcal disease and annually against influenza virus according to G.S. 131D-9, except as otherwise indicated in ~~this~~ law.

~~(e) The home shall make arrangements for any resident, who has been an inpatient of a psychiatric facility within 12 months before entering the home and who does not have a current plan for psychiatric care, to be examined by a local~~

~~physician or a physician in a mental health center within 30 days after admission and to have a plan for psychiatric follow-up care when indicated.~~

(j) The facility shall make arrangements for a resident to be evaluated by a licensed mental health professional, licensed physician or licensed physician extender for follow-up psychiatric care within 30 days of admission or re-admission to the facility when the resident:

(1) has been an inpatient of a psychiatric facility within 12 months prior to admission to the facility and does not have a current plan for follow-up psychiatric care; or

(2) has been hospitalized due to threatening or violent behavior, suicidal ideation or self-harm, or other psychiatric symptoms that required hospitalization within 12 months prior to admission to the facility and does not have a current plan for follow-up psychiatric care.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. December 1, 1993; July 1, 1990; April 1, 1987; April 1, 1984;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, ~~2004.~~ 2004;
Readopted Eff. January 1, 2024.

REQUEST FOR CHANGES PURSUANT TO G.S. 150B-21.10

AGENCY: N.C. Medical Care Commission

RULE CITATION: 10 NCAC 13G .0703

DEADLINE FOR RECEIPT: December 8, 2023

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may email the reviewing attorney to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following changes be made:

This page intentionally left blank.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

William W. Peaslee
Commission Counsel
Date submitted to agency: November 28, 2023

10A NCAC 13G .0703 is repealed through readoption as published in 37:24 NCR 2219-2227 as follows:

10A NCAC 13G .0703 RESIDENT REGISTER

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1987; April 1, 1984;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. April 1, 2022; July 1, ~~2005.~~ 2005;
Repealed Eff. January 1, 2024.

REQUEST FOR CHANGES PURSUANT TO G.S. 150B-21.10

AGENCY: N.C. Medical Care Commission

RULE CITATION: 10 NCAC 13G .1102

DEADLINE FOR RECEIPT: December 8, 2023

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may email the reviewing attorney to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following changes be made:

Page 1, Line 4: Who determines when the resident is "unable to manage" their finances?

Page 1, Line 5: What happens if the resident has stated, either in writing or verbally, that the resident's family is not to be notified? What if the resident has designated a non-family member as the point of contact or has an attorney-in-fact designated?

Page 1, Lines 7-8: As written, an incompetent resident could sign the written authorization. Was that the Commission's intention?

Page 1, Lines 8-9: This line seems like it should be part of Paragraph (b).

Page 1, Line 13: The administrator is required to give the payee of any monies receipts? Please explain.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

William W. Peaslee
Commission Counsel
Date submitted to agency: November 28, 2023

10A NCAC 13G .1102 is readopted as published in 37:24 NCR 2219-2227 as follows:

10A NCAC 13G .1102 ~~LEGAL~~ AUTHORIZED REPRESENTATIVE ~~OR PAYEE~~

(a) In situations where a resident of a family care home is unable to manage ~~his funds,~~ their monetary funds the administrator shall contact a family member or the county department of social services regarding the need for a ~~legal representative or payee.~~ authorized representative. For the purposes of this Rule, an "authorized representative" shall mean a person who is legally authorized or designated in writing by the resident to act on his or her behalf in the management of their funds. The administrator and other staff of the ~~home~~ facility shall not serve as a resident's ~~legal~~ authorized representative, payee, or executor of a will, except as indicated in Paragraph (b) of this Rule.

(b) In the case of funds administered by the Social Security Administration, the Veteran's Administration or other federal government agencies, the administrator of the ~~home~~ facility may serve as a payee when so authorized as a legally constituted authority by the respective federal agencies.

(c) The administrator shall give the resident's ~~legal~~ authorized representative ~~or payee~~ receipts for any monies received on behalf of the resident.

History Note: *Authority G.S. 35A-1203; 108A-37; 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, ~~1984.~~ 1984;
Effective January 1, 2024.

REQUEST FOR CHANGES PURSUANT TO G.S. 150B-21.10

AGENCY: N.C. Medical Care Commission

RULE CITATION: 10 NCAC 13G .1103

DEADLINE FOR RECEIPT: December 8, 2023

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may email the reviewing attorney to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following changes be made:

Page 1, Lines 7, 10, 13: Define "authorized representative".

Page 1, Lines 10-14: The language is permissive in nature and their does not appear to be an restriction which would prohibit the activity.

Consider, "No employee of a facility shall handle a resident's monies, except for the facility administrator or the administrator's designee after having received prior written authorization from the resident or the resident's lawful representative. The facility shall maintain an accurate account balance and accounting of all receipts and disbursements, which shall be available upon request to the resident or their lawful representative during the facility's regular business office hours.

Page 1, Lines 15-21: Here the Commission uses the term "personal funds" but Paragraph (b) states "personal monies". Unless the Commission is addressing different things, be consistent with the terms.

Page 1, Lines 15-21: As written, the resident must verify the accuracy of the "disbursement of personal funds" but the authorized representative is only verifying receipt of the record. Is that what the Commission intended?

Page 1, Lines 15-21: The passive voice is used. Consider, "The facility shall provide each resident or the resident's lawful representative a written monthly accounting of the resident's monies handled by the administrator or the administrator's designee. The facility shall maintain at the facility a record signed by the resident or their lawful representative indicating whether the resident or their lawful representative agree that the monthly accounting is accurate.

Page 1, Lines 15-21: How long must the records be maintained?

William W. Peaslee
Commission Counsel
Date submitted to agency: November 28, 2023

Page 1, Lines 22-23: As written, the facility can commingle a resident's funds with other residents' funds so long as it is a non-interest baring account. Is that correct? The facility can hold a resident's funds in an interest baring account so long as no other resident's funds are in that account. Is that correct? Who gets the interest?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

William W. Peaslee
Commission Counsel
Date submitted to agency: November 28, 2023

10A NCAC 13G .1103 is readopted as published in 37:24 NCR 2219-2227 as follows:

10A NCAC 13G .1103 ACCOUNTING FOR RESIDENT'S PERSONAL FUNDS

(a) To document a resident's receipt of the State-County Special Assistance personal needs allowance after payment of the cost of care, a statement shall be signed by the resident or marked by the ~~resident with two witnesses' signatures.~~ resident. If the statement is marked by the resident, there shall be one witness signature. For residents who have been adjudicated incompetent, the signature of the resident's authorized representative shall be required. Witnesses cannot include the staff handling the residents' personal funds transactions. The statement shall be maintained in the ~~home.~~ facility.

(b) Upon the written authorization of the resident or ~~his legal representative or payee,~~ their authorized representative, an administrator or the administrator's designee may handle the personal money for a resident, provided an accurate accounting of monies received and disbursed and the balance on hand is available upon request of the resident or ~~his legal representative or payee.~~ their authorized representative during the facility's established business days and hours.

(c) A record of each transaction involving the use of the resident's personal funds according to Paragraph (b) of this Rule shall be signed by the ~~resident, legal representative or payee~~ the resident or the resident's authorized representative, or marked by the ~~resident, if not adjudicated incompetent, with two witnesses' signatures~~ resident, at least monthly verifying the accuracy of the disbursement of personal funds. If marked by the resident, there shall be one witness signature. For residents who have been adjudicated incompetent, the facility shall provide the resident's authorized representative with a copy of the monthly resident's funds statement and shall obtain verification of receipt. The ~~record~~ records shall be maintained in the ~~home.~~ facility.

(d) A resident's personal funds shall not be commingled with facility funds. The facility shall not commingle the personal funds of residents in an interest-bearing account.

(e) All or any portion of a resident's personal funds shall be available to the resident or ~~his legal~~ their authorized representative ~~or payee~~ upon request during ~~regular office hours~~, the facility's established business days and hours except as provided in Rule .1105 of this Subchapter.

(f) The resident's personal needs allowance shall be credited to the resident's account within ~~24 hours of the check being deposited following endorsement.~~ one business day of the funds being available in the facility's resident personal funds account.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. April 1, 1984;
Amended Eff. July 1, 2005; April 1, ~~1987.~~ 1987;
Readopted Eff. January 1, 2024.

REQUEST FOR CHANGES PURSUANT TO G.S. 150B-21.10

AGENCY: N.C. Medical Care Commission

RULE CITATION: 10 NCAC 13G .1106

DEADLINE FOR RECEIPT: December 8, 2023

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may email the reviewing attorney to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following changes be made:

Generally, to the rule: It appears that the Commission is attempting to regulate contractual obligations between the facilities and residents. It does not appear that the Commission has authority over residents, or at least not a viable enforcement mechanism. The Commission

Page 1, Line 4-6: This is grammatically incorrect. Consider changing.

Page 1, Lines 11-13: Explain the Commission's authority over former residents or to determine or adjudicate the contractual obligations of a former resident. Also, explain how this will be enforced. What will the Commission or department do in the event of non-payment?

Page 1, Lines 11-12: It is unclear whether moving out pursuant to .0705(i) is an example of a resident moving out without giving notice, or whether the paragraph applies in this exclusive circumstance. It can be read two ways.

Page 1, Lines 13-15: "Entitled" from whom?

Page 1, Lines 13-15: Explain the Commission's authority over former residents or to determine or adjudicate the contractual obligations of a former resident.

Page 1, Lines 19-21: Explain the Commission's authority over former residents or to determine or adjudicate the contractual obligations of a former resident.

Page 1, Line 23-24: Rule .0705(i) does not require notice. It is unclear what the Commission intends by the inclusion of the reference.

Page 1, Lines 27-36, and Page 2, Lines 1-14: Paragraph (e) is poorly written and is confusing. It should be re-written.

Page 1, Line 27: Who determines the intent?

William W. Peaslee
Commission Counsel
Date submitted to agency: November 28, 2023

Page 1, Lines 28 and 30: The Commission is using permissive language when there does not appear to be a restriction. Put another way, in the absence of a restriction, the parties to an agreement can agree as they will.

Page 1, Lines 34-36: I think the Commission is attempting to prohibit facilities from enforcing any notice requirements unless those requirements are explained the resident or their lawful representative, provided in writing and signed by the resident or their lawful representative. However, it is unclear.

Page 2, Line 4: Change "may" to "shall". This would be clearer and more concise if put in the active voice.

Page 2, Lines 13-15: A refund shall be given by whom? This would be clearer and more concise if put in the active voice. "The adult day care facility shall provide a refund of….to….when…"

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

William W. Peaslee
Commission Counsel
Date submitted to agency: November 28, 2023

10A NCAC 13G .1106 is readopted as published in 37:24 NCR 2219-2227 as follows:

10A NCAC 13G .1106 SETTLEMENT OF COST OF CARE

(a) If a resident of a family care home, after being notified by the ~~home~~ facility of its intent to discharge the resident in accordance with Rule .0705 of this Subchapter, ~~moves out of the home before the period of time specified in the notice has elapsed,~~ the ~~home~~ facility shall refund the resident an amount equal to the cost of care for the remainder of the month minus any nights spent in the ~~home~~ facility during the notice period. The refund shall be made within 14 days after the resident leaves the ~~home.~~ facility. For the purposes of this Rule, "cost of care" means any monies paid by the resident or the resident's legal representative in advance for room and board and services provided by facility as agreed upon in the resident's contract.

(b) If a resident moves out of the ~~home~~ facility without giving notice, as may be required by the ~~home~~ facility according to Rule ~~.0705(h)~~ .0705(i) of this Subchapter, or before the ~~home's~~ facility's required notice period has elapsed, the resident owes the ~~home~~ facility an amount equal to the cost of care for the required notice period. If a resident receiving State-County Special Assistance moves without giving notice or before the notice period has elapsed, the former ~~home~~ facility is entitled to the required payment for the notice period before the new ~~home~~ facility receives any payment. The ~~home~~ facility shall refund the resident the remainder of any advance payment following settlement of the cost of care. The refund shall be made within 14 days from the date of notice or, if no notice is given, within 14 days of the resident leaving the ~~home.~~ facility.

(c) When there is an exception to the notice as provided in Rule ~~.0705(h)~~ .0705(i) of this Subchapter to protect the health or safety of the resident or others in the ~~home,~~ facility, or when there is a sudden, unexpected closure of the facility that requires the resident to relocate, the resident is only required to pay for any nights spent in the ~~home.~~ facility. A refund shall be made to the resident by the ~~home~~ facility within 14 days from the date of notice.

(d) When a resident gives notice of leaving the ~~home,~~ facility, as may be required by the ~~home~~ facility according to Rule ~~.0705(h)~~ .0705(i) of this Subchapter, and leaves at the end of the notice period, the ~~home~~ facility shall refund the resident the remainder of any advance payment within 14 days from the date of notice. If notice is not required by the ~~home,~~ facility, the refund shall be made within 14 days after the resident leaves the ~~home.~~ facility.

(e) When a resident leaves the ~~home~~ facility with the intent of returning to it, the following apply:

(1) The ~~home~~ facility may reserve the resident's bed for a set number of days with the written agreement of the ~~home~~ facility and the resident or his or her responsible person and thereby require payment for the days the bed is held.

(2) If, after leaving the ~~home,~~ facility, the resident decides not to return to it, the resident or someone acting on his or her behalf may be required by the ~~home~~ facility to provide up to a 14-day written notice that he or she is not returning.

(3) Requirement of a notice, if it is to be applied by the ~~home,~~ facility, shall be a part of the written agreement and explained by the ~~home~~ facility to the resident and his or her family or responsible person before signing.

(4) On notice by the resident or someone acting on his or her behalf that he or she will not be returning to the ~~home,~~ facility, the ~~home~~ facility shall refund the remainder of any advance payment to the resident or his or her responsible person, minus an amount equal to the cost of care for the period covered by the agreement. The refund shall be made within 14 days after notification that the resident will not be returning to the ~~home.~~ facility.

(5) In no situation involving a recipient of State-County Special Assistance may a ~~home~~ facility require payment for more than 30 days since State-County Special Assistance is not authorized unless the resident is actually residing in the ~~home~~ facility or it is anticipated that he or she will return to the ~~home~~ facility within 30 days.

(6) Exceptions to the ~~two-weeks'~~ 14-day notice, if required by the ~~home,~~ facility, are cases where returning to the ~~home~~ facility would jeopardize the health or safety of the resident or others in the ~~home~~ facility as certified by the resident's physician or approved by the county department of social services, and in the case of the resident's death. In these cases, the ~~home~~ facility shall refund the rest of any advance payment calculated beginning with the day the ~~home~~ facility is notified.

(f) If a resident dies, the administrator of his or her estate or the Clerk of Superior Court, when no administrator for his or her estate has been appointed, shall be given a refund equal to the cost of care for the month minus any nights spent in the ~~home~~ facility during the month. This is to be done within 30 days after the resident's death.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; June 1, 1987; April 1, 1984;
Temporary Amendment Eff. January 1, 2001;
Temporary Amendment Expired October 13, 2001;
Amended Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. January 1, 2024.