STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060171	A. BUILDING: _____ B. WING _____	R 06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLISSFUL LIVING SENIOR CARE	8901 ROBINSON CHURCH ROAD CHARLOTTE, NC 28215

(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 annual and follow up survey on 06/01/23.	C 000	Plan of Corrections	
C 203	10A NCAC 13G .0702 (b) Tuberculosis Test And Medical Examination 10A NCAC 13G .0702 Tubercluosis Test And Medical Examination (b) Each resident shall have a medical examination prior to admission to the home and annually thereafter. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure an FL-2 was completed for 1 of 2 sampled residents (#1), annually. The findings are: Review of Resident #1's current FL-2 dated 02/17/22 revealed diagnoses included dementia, hypertension and impairment of balance. Review of Resident #1's resident register revealed she was admitted on 02/15/22. Review of Resident #1's record on 06/01/23 revealed her last FL-2 was dated 02/17/22. Interview with the Supervisor in Charge (SIC) on 06/01/23 at 1:59pm revealed she knew residents were required to have a signed FL-2 on admission but was not aware that a new FL-2 should be completed and signed annually. Interview with the Administrator on 06/01/23 at	C 203	Measures we put in place to prevent recurrence and to correct the deficiency. Supervisor in charge will ensure that the FL2 will be signed by the Provider on or before the residents Anniversary date. By adding the Resident admission dates on the computer calendar and setting up a reminder . The Administrator will follow up with a two way check to ensure the Accuracy . Facility Provider came for recurrence visit to Residents on 6/12/23 Assesses each Resident and reviewed and signed their FL2 see attachment.	6/14/2023 6/12/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M. N. P | TITLE: Administrator | (X6) DATE: 6/14/23

Reviewed and acknowleged 06/15/23
Brianna Jameson RD, LDN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 203	*Continued From page 1* 1:54pm revealed: -He and the SIC ensured residents had a signed FL-2 when they were admitted to the facility. -He was not aware residents were required to have an FL-2 completed and signed by the provider annually.	C 203		