Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from 02/04/26 to 02/06/26.	{D 000}		
{D 194}	10A NCAC 13F .0608 (a)(b) Staffing for Facilities With A Census Of 21 10A NCAC 13F .0608 Staffing for Facilities With A Census Of 21 Or More Residents (a) Each facility with a census of 21 or more residents shall have staff on duty to meet the needs of the residents. (b) In addition to the requirement in Paragraph (a) of this Rule, each facility with a census of 21 or more residents shall comply with the following staffing requirements: (1) On first shift and second shift, the total aide duty hours shall be at least: (A) 16 hours of aide duty for facilities with a census of 21 to 40 residents. (B) 20 hours of aide duty for facilities with a census of 41 to 50 residents. (C) 24 hours of aide duty for facilities with a census of 51 to 60 residents. (D) 28 hours of aide duty for facilities with a census of 61 to 70 residents. (E) 32 hours of aide duty for facilities with a census of 71 to 80 residents. (F) 36 hours of aide duty for facilities with a census of 81 to 90 residents. (G) 40 hours of aide duty for facilities with a census of 91 to 100 residents. (H) 44 hours of aide duty for facilities with a census of 101 to 110 residents. (I) 48 hours of aide duty for facilities with a census of 111 to 120 residents. (J) 52 hours of aide duty for facilities with a census of 121 to 130 residents. (K) 56 hours of aide duty for facilities with a	{D 194}	Responses to cited deficiencies do not constitute an admission or agreement by the facility of truth of facts alleged or conclusions set forth in the Statement of Deficiencies or the Corrective Action Report. The Plan of Correction is prepared solely as a matter of compliance with state 10A NCAC 13F .0608 (a)(b) Staffing of Facilities with a Census of 21 or More Residents Community ED will assure that community is staffed according to regulations. Community hosted a job fair and is hosting open interviews two days a week. Regional Support in serviced ED, Care Coordinators, and BOC on rule .0608 utilizing DHSR "Staffing of Licensed Adult Care Homes" power point.	03/22/26 02/10/26 02/11/26

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{D 194}	Continued From page 1 census of 131 to 140 residents. (L) 60 hours of aide duty for facilities with a census of 141 to 150 residents. (M) 64 hours of aide duty for facilities with a census of 151 to 160 residents. (N) 68 hours of aide duty for facilities with a census of 161 to 170 residents. (O) 72 hours of aide duty for facilities with a census of 171 to 180 residents. (P) 76 hours of aide duty for facilities with a census of 181 to 190 residents. (Q) 80 hours of aide duty for facilities with a census of 191 to 200 residents. (R) 84 hours of aide duty for facilities with a census of 201 to 210 residents. (S) 88 hours of aide duty for facilities with a census of 211 to 220 residents. (T) 92 hours of aide duty for facilities with a census of 221 to 230 residents. (U) 96 hours of aide duty for facilities with a census of 231 to 240 residents. (2) On third shift, the total aide duty hours shall be at least: (A) 8 hours of aide duty for facilities with a census of 21 to 30 residents. (B) 16 hours of aide duty for facilities with a census of 31 to 60 residents. (C) 24 hours of aide duty for facilities with a census of 61 to 90 residents. (D) 32 hours of aide duty for facilities with a census of 91 to 120 residents. (E) 40 hours of aide duty for facilities with a census of 121 to 150 residents. (F) 48 hours of aide duty for facilities with a census of 151 to 180 residents. (G) 56 hours of aide duty for facilities with a census of 181 to 210 residents. (H) 64 hours of aide duty for facilities with a census of 211 to 240 residents.	{D 194}	Community has implemented a Manager On Duty (MOD) schedule for weekends to assist in assuring accurate staffing is in place. Regional Support reviewed and trained ED and BOC on reading and understanding of the labor report. ED conducted a staff meeting to review policies and procedures, staffing ratios, and the importance of adequate staffing at community. ED and Care Coordinators will create and review schedule together for 30 days and the Care Coordinators will continue to complete schedule thereafter. ED and/or BOC will review timecards daily to assure employees are clocking into correct department. Missed punches to be reviewed at daily stand up with ED. ED and/or designee will review and sign off on weekly schedule to ensure proper staffing for 30 days.	02/17/26 03/11/26 03/12/26 03/22/26 03/22/26 03/22/26

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{D 194}	Continued From page 2 (3) If the Department determines the needs of the residents at a facility are not being met by staffing requirements of Paragraph (b) of this Rule, the Department shall require the facility to employ staff to meet the needs of the residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews and record reviews, the facility failed to meet the minimum required aide hours to meet the needs of residents residing in the Assisted Living (AL) unit for 15 of 27 sampled shifts from 01/10/26 to 01/18/26. The findings are: Review of the facility's current license effective 01/01/26 revealed the facility was an Adult Care Home with a capacity for 94 residents, 46 of which were Special Care Unit (SCU) beds. Review of the facility's census dated 02/04/26 revealed a census of 42 residents residing in the AL.	{D 194}	ED, Care Coordinators, and BOC will review daily staffing and call outs during morning meeting. ED, Care Coordinators, and/or other designee will conduct multiple random walk throughs of facility to ensure proper staffing. Regional Support, ED and/or other designee will review labor report daily for 30 days and then weekly thereafter for the next quarter to ensure adequate staffing requirements are being met.	03/22/26 03/22/26 03/22/26

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{D 194}	Continued From page 3 Review of the AL census dated 01/10/26-01/18/26 revealed a census of 45 residents, requiring 20 aide hours on first and second shift and 16 aide hours on third shift. Review of the time punch cards for staff on 01/10/26 revealed: -There was a total of 16.75 aide hours provided on second shift leaving a shortage of 3.25 aide hours. -There was a total of 8.25 aide hours provided on third shift leaving a shortage of 7.50 aide hours. Review of the time punch cards for staff on 01/11/26 revealed: -There was a total of 16 aide hours provided on first shift and on second shift leaving a shortage of 4 aide hours on each shift. -There was a total of 1.50 aide hours provided on third shift leaving a shortage of 14.50 aide hours. Review of the time punch cards for staff on 01/13/26 revealed: -There was a total of 13.25 aide hours provided on second shift leaving a shortage of 11.25 aide hours. -There was a total of 7.75 aide hours provided on third shift leaving a shortage of 8.25 aide hours. Review of the time punch cards for staff on 01/14/26 revealed: -There was a total of 8.75 aide hours provided on second shift leaving a shortage of 6.5 aide hours. -There was a total of 13 aide hours provided on third shift leaving a shortage of 3 aide hours. Review of the time punch cards for staff on 01/15/26 revealed there was a total of 8 aide hours provided on third shift leaving a shortage of 8 aide hours.	{D 194}		

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{D 194}	Continued From page 4	{D 194}		

Review of the time punch cards for staff on 01/16/26 revealed:
-There was a total of 15.25 aide hours provided on second shift leaving a shortage of 4.75 aide hours.
-There was a total of 4.50 aide hours provided on third shift leaving a shortage of 11.50 aide hours.

Review of the time punch cards for staff on 01/17/26 revealed there was a total of 11.75 aide hours provided on third shift leaving a shortage of 4.25 aide hours.

Review of the time punch cards for staff on 01/18/26 revealed:
-There was a total of 12.75 aide hours provided on second shift leaving a shortage of 7.25 aide hours.
-There was a total of 12.25 aide hours provided on third shift leaving a shortage of 3.75 aide hours.

Interview with a resident on 02/06/26 at 8:00am revealed:
-It took 45 minutes for a response from staff on most evenings and weekends; when staff finally responded to the call bell, staff said they would be back but did not return.
-The facility was short staffed a lot and especially during the weekends.

Interview with a second resident on 02/06/26 at 9:00am revealed:
-The facility was short staffed a lot and especially during the weekends.
-She had waited 40-45 minutes for an aide to respond to her call light several times in the evenings and on the weekends.
-She had seen only 1 personal care aide (PCA)

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{D 194}	Continued From page 5 working at the facility sometimes in the evenings and on the weekend. Interview with a PCA on 02/06/26 at 7:30am revealed: -She had worked on second shift for the AL but switched to first shift due to being tired of not having help on second shift. -She had worked as the only PCA on second shift before due to excessive staff "call-outs" that were not covered for the AL. -They were fully staffed mostly on first shift but second and third shift were always short staffed. -She worked first shift and had come to work several times on the weekends and there would not be enough PCAs in the facility. Interview with a second PCA on 02/06/26 at 7:52am revealed: -The staff rotated from the SCU to the AL on the schedule. -There was enough staff on first shift, but not always enough staff on second shift. -If a PCA called out, the Resident Care Coordinator (RCC) or the Special Care Unit Coordinator (SCUC) were responsible for either finding coverage or working their shift. Interview with a medication aide (MA) on 02/06/26 at 8:17am revealed: -The facility did not have a full staff on some days and there were times when the AL had only 1 PCA to cover the care needs of the AL residents. -Some staff would come in late, call out, or not show up because the weekends were short staffed. -The SCUC and the RCC were supposed to fill in on shifts when "call-outs" occurred or when there was a staff shortage for the AL.	{D 194}		

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{D 194}	Continued From page 6 Interview with another MA on 02/06/26 at 2:15pm revealed: -She had worked second shift as an MA when there were staff shortages and worked with only 1 PCA during the whole shift. -Staffing shortages on second and third shift were a "normal" expectation from staff who had been at the facility for a while. Interview with the SCUC on 02/06/26 at 9:23am revealed: -She was aware of staffing shortages in the AL within previous weeks but there were a lot of "call-outs" by staff. -There were times they had a lot of "call-outs" and could not find coverage due to high turnover. -Sometimes the staff called the SCUC or the RCC to let them know when there were call-outs, but not every time. -When she was aware of the call-outs, she tried to find another staff member to come in or she and the RCC covered the shift. Interview with the RCC on 02/06/26 at 9:45am revealed: -Both she and the SCUC were responsible for covering staff shortages on the AL and the Special Care Unit (SCU); but sometimes the shifts were short even if the she and the SCUC worked a shift. -She encouraged staff to find their own coverage but she and the SCUC covered the shift when coverage could not be obtained. -She was aware of staffing shortages in the AL within previous weeks but they experienced issues with staff turnover. -Sometimes the staff called the SCUC or the RCC to let them know when there were call-outs, but not every time.	{D 194}		

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{D 194}	Continued From page 7 Interview with the Administrator on 02/06/26 at 10:02am revealed: -The SCUC and the RCC were responsible for scheduling and ensuring there were enough PCAs for the AL. -She had noticed the AL was short-staffed but they had worked on increasing staffing since her arrival on 01/28/26 due to high staff turnover issues. -She expected the AL to be staffed according to regulations and to accommodate the personal care needs of the residents. _____ The facility failed to ensure the minimum number of staff were present at all times on all three shifts to meet the needs of residents residing in the AL for 15 of 27 shifts sampled over 9 days from 01/10/26 to 01/18/26. The facility's failure to provide sufficient staffing to meet the needs of residents in the AL was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/06/26.	{D 194}		
{D 358}	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	{D 358}		

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{D 358}	Continued From page 8 This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION. Based on these findings, the previous Type A2 Violation was abated but noncompliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 7 residents related to errors with sliding scale insulin (#6). The findings are: Review of Resident #6's current FL-2 dated 07/01/25 revealed: -Diagnoses included vascular dementia and type 2 diabetes mellitus. -There was an order for insulin regular (a medication used to treat diabetes mellitus) 100 unit/mL, check blood sugar (BS) three times daily and inject insulin subcutaneously per sliding scale: less than 70, call provider; if BS 121 to 150, administer 2 units; if BS 151 to 200, administer 4 units; if BS 201 to 250, administer 5 units; if BS 251 to 300, administer 6 units; if BS 301 to 350, administer 8 units; if BS 351 to 400, administer 10 units; if BS greater than 500, call provider. Review of Resident #6's signed physician order dated 12/03/25 revealed: -There was an order to change the sliding scale for insulin regular. -There was an order to check BS and inject based on sliding scale: 70-120 = skip dose, 121-150= 4 units, 151-200 = 6 units, 201-250 = 8 units, 251-300 = 10 units, 301-350 = 12 units, 351	{D 358}	10A NCAC 13F .1004(a) Medication Administration Care Coordinators and/or designee will conduct audit on diabetic residents for insulin administration. RCD/RN conducted in service conducted with Care Coordinators on insulin documentation and administration, medication refusals and process for reporting refusals. ED and/or CC will conduct a review of EMARS for diabetic residents weekly for 30 days then no less than monthly there after. Regional Clinical Director, RN will review EMARS monthly for two months Medication cart audit are to be reviewed with ED weekly during standup meeting.	02/13/26 02/25/26 03/22/26 03/22/26

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{D 358}	Continued From page 9 or higher = 14 units. Review of Resident #6's December 2025 electronic medication administration record (eMAR) from 12/08/25 to 12/31/25 revealed: -There was an entry for insulin regular flexpen 100 units/ml, if BS before each meal was under 120 then skip dose, 121-150= 4 units, 151-200 = 6 units, 201-250 = 8 units, 251-300 = 10 units, 301-350 = 12 units, 351-400 = 14 units, call provider if over 400. -There was a space on the eMAR to document Resident #6's BS reading but there was nowhere to document the number of insulin units administered. -It could not be determined how many units of insulin Resident #6 should have been administered for 27 of 72 instances where there was no documentation of Resident #6's BS results. -It could not be determined how many units of insulin were administered to Resident #6 for 64 of 72 instances where there were no unit amounts of insulin documented on the eMAR. -Resident #6's BS ranged from 66-319 for documented BS readings. Review of Resident #6's January 2026 eMAR revealed: -There was an entry for insulin regular flexpen 100 units/ml, if BS before each meal was under 120 then skip dose, 121-150= 4 units, 151-200 = 6 units, 201-250 = 8 units, 251-300 = 10 units, 301-350 = 12 units, 351-400 = 14 units, call provider if over 400. -There was a space on the eMAR to document Resident #6's BS reading but there was nowhere to document the number of insulin units administered. -It could not be determined how many units of	{D 358}	ED and Care Coordinators will conduct daily reviews of YARDI dashboards to include progress notes, med administration, and incident reports for 30 days and then no less than weekly thereafter. RCD/RN will conduct on site and/or remotely reviews of YARDI reports to ensure follow up on medication administration for 30 days. RCD/RN and Regional Support will review quarterly pharmacy review visit summaries with ED and CC's during visits to community. RCD/RN will conduct random med pass observations during weekly site visits. RCD and Regional support will visit community no less than twice weekly for 30 days and then weekly thereafter.	03/22/26 03/22/26 03/22/26 03/22/26 03/22/26

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insulin Resident #6 should have been administered for 7 of 92 instances where there was no documentation of Resident #6's BS results.
-It could not be determined how many units of insulin Resident #6 was administered for 67 of 92 instances where there were no unit amounts of insulin documented on the eMAR.
-There was documentation 10 units of insulin were administered instead of 12 units for a BS value of 331 on 01/29/26 at 4:30pm.
-Resident #6's BS ranged from 69-451 for documented BS readings.

Review of Resident #6's February 2026 eMAR revealed:
-There was an entry for insulin regular flexpen 100 units/ml, if BS before each meal was under 120 then skip dose, 121-150= 4 units, 151-200 = 6 units, 201-250 = 8 units, 251-300 = 10 units, 301-350 = 12 units, 351-400 = 14 units, call provider if over 400.
-There was a space on the eMAR to document Resident #6's BS reading but there was nowhere to document the number of insulin units administered.
-It could not be determined how many units of insulin were administered to Resident #6 for 13 of 16 instances where there were no unit amounts of insulin documented on the eMAR.
-Resident #6's BS ranged from 70-340.

Observation of the medications on hand for Resident #6 on 02/06/25 at 2:15pm revealed there was a 3ml (100 units/mL) insulin regular pen opened on 02/06/25 available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 02/06/26 at

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1:33pm revealed:
-Resident #6 had an active order for insulin regular flexpen 100 units/ml, check BS before meals, if BS was under 120 then skip dose, 121-150= 4 units, 151-200 = 6 units, 201-250 = 8 units, 251-300 = 10 units, 301-350 = 12 units, 351-400 = 14 units, call provider if over 400.
-Resident #6's insulin regular was dispensed on 12/04/25, 12/28/25 and 01/24/25 for a quantity of three 3ml (100 units/mL) insulin regular flexpens for each dispensed date.

Telephone interview with Resident #6's on-call provider on 02/06/26 at 3:15pm revealed:
-She did not know the facility did not document the number of regular insulin units administered to Resident #6 for 64 instances in December 2025, 67 instances in January 2026, and 13 instances in February 2026.
-She would expect the facility to document how many units of insulin were administered to Resident #6.
-She was not concerned about hypoglycemia (low blood sugar) if the facility was checking the BS before the next insulin dose was due.

Interview with a medication aide (MA) on 02/06/26 at 3:20pm revealed:
-Resident #6 was always administered insulin but it was not being documented.
-Resident #6 would ask staff for her insulin if it were not administered.
-Resident #6's regular insulin order was a sliding scale and she always tried to document the number of insulin units she administered to Resident #6 in a progress note.
-There was a space on the eMAR to document Resident #6's BS value but there was nowhere to document the number of insulin units administered.

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ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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
{D 358}	Continued From page 12 -Resident #6 had never refused insulin administration. -She and other MAs performed audits by printing physician orders and comparing physician orders to medications on the medication cart. -She normally completed audits on Mondays, Wednesdays and Fridays and audited four residents' medications per day. -Her last completed audit was on 02/03/26. -The Resident Care Coordinator (RCC) faxed new orders and order changes to the pharmacy and the pharmacy placed order entries on the eMAR. -MAs were unable to place order entries on the eMAR. Interview with another MA on 02/06/26 at 3:40pm revealed: -Resident #6 had never refused insulin administration and she would ask staff for her insulin if it was not administered. -There was a space on the eMAR to document Resident #6's BS value but there was nowhere to document the number of insulin units administered. -Resident #6's regular insulin order was a sliding scale but she had not been told to document the number of insulin units she administered to Resident #6 in a progress note. -She and other MAs performed audits every day by printing physician orders and comparing physician orders to medications on the medication cart. -The RCC and the Special Care Unit Coordinator (SCUC) completed eMAR and medication cart audits weekly. -MAs were unable to place order entries on the eMAR but faxed new orders and order changes to the pharmacy. -The RCC and the pharmacy placed order entries	{D 358}		

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{D 358}	Continued From page 13 on the eMAR. Interview with Resident #6 on 02/06/26 at 3:49pm revealed: -Staff administered her insulin. -She had not missed any insulin doses since December 2025 and she had never refused any insulin doses. -The MAs utilized her continuous glucose monitor for blood sugar readings and did not obtain finger sticks. -She would always report to staff when her glucose monitor alarmed for high or low blood sugar readings and MAs would ask to see the readings on the monitor. Interview with the SCUC on 02/06/26 at 3:40pm revealed: -She administered insulin to Resident #6 twice in December 2025. -The electronic medication documentation system prompted her to administer a certain number of units to Resident #6 based on the BS value when she administered insulin to Resident #6. -She did not know the number of units she administered to Resident #6 was not documented on the eMAR. -She thought the number of units she administered to Resident #6 was automatically documented based on the prompt to administer a certain amount of insulin units. -She did not know there was no documentation for the number of regular insulin units administered to Resident #6 for 64 instances in December 2025, 67 instances in January 2026, and 13 instances in February 2026. -The pharmacy placed medication order entries on the eMAR. Interview with the RCC on 02/06/26 at 3:55pm	{D 358}		

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{D 358}	Continued From page 14	{D 358}		

revealed:
-She did not know the number of regular insulin units administered to Resident #6 was not documented for 64 instances in December 2025, 67 instances in January 2026, and 13 instances in February 2026.
-She thought the number of units was documented on the eMAR as they had been with Resident #6's previous insulin order prior to 12/03/25.
-The pharmacy placed medication order entries on the eMAR but she had to approve orders as the RCC.
-Resident #6 had not missed insulin doses but the amount of insulin administered was not documented.
-She thought something was missing when Resident #6's regular insulin order was entered into the eMAR system and a box was not checked to allow a place on the eMAR for number of insulin units administered to be documented.
-None of the MAs told her they were unable to document the number of insulin units administered on the eMAR for Resident #6.
-She and the MAs completed medication cart audits.
-The last audit she completed was sometime during the week of 01/25/26 to 01/31/26.
-MAs were expected to complete audits by comparing physician orders to the medication on the eMAR.
-Whoever administered insulin to Resident #6 was responsible for documenting the number of insulin units administered to Resident #6 when they administered it.

Interview with the Administrator on 02/06/26 4:10pm revealed:
-She did not know the number of regular insulin

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{D 358}	Continued From page 15	{D 358}		

units administered to Resident #6 were not documented for 64 instances in December 2025, 67 instances in January 2026, and 13 instances in February 2026 prior to 02/06/26.
-When she administered insulin, the order would pop up on the computer screen, she entered a BS value, and the eMAR would instruct her how many units of insulin to administer based on the BS value.
-She did not know the number of insulin units administered were not being documented.
-The MA or whoever administered insulin to Resident #6 was responsible for documenting the number of insulin units administered to Resident #6.
-MAs completed medication cart audits at least twice weekly.
-When a resident had a new order, the facility sent the order to the pharmacy, the pharmacy keyed the order into the eMAR, and the RCC, SCUC, or Administrator verified the order prior to administration.

Attempted telephone interview with Resident #6's primary care provider (PCP) on 02/06/25 at 2:18pm was unsuccessful.

The facility failed to document the blood sugar values and the number of units of insulin administered for 1 of 7 sampled residents; therefore, it could not be determined if the resident received the correct amount of insulin. This failure placed the resident at risk for hypoglycemia (low blood sugar) and hyperglycemia (elevated blood sugar). This failure was detrimental to the health, safety and welfare of the resident which constitutes a Type B Violation.

The facility provided a plan of protection in

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{D 358}	Continued From page 16 accordance with G.S. 131D-34 on 02/06/26. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 23, 2026.	{D 358}		
{D 465}	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. Based on these findings, the previous Type B Violation was not abated. Based on record reviews, observations and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 25 of 27 shifts sampled from 01/10/26-01/18/26. The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was an Adult Care Home with a capacity for 78 residents, 20 of which were Special Care Unit (SCU) beds.	{D 465}		

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{D 465}	Continued From page 17 Review of the SCU census dated 01/10/26-01/18/26 revealed a census of 40 residents, requiring 40 aide hours on first and second shift and 32 hours on third shift. Review of the time punch cards for staff on 01/10/26 revealed: -There were 30.25 total aide hours provided on first shift leaving a shortage of 9.75 aide hours. -There were 20.75 total aide hours provided on second shift leaving a shortage of 19.25 aide hours. -There were 9.50 total aide hours provided on third shift leaving a shortage of 22.50 aide hours. Review of the time punch cards for staff on 01/11/26 revealed: -There were 35.75 total aide hours provided on second shift leaving a shortage of 4.25 aide hours. -There were 1.50 total aide hours provided on third shift leaving a shortage of 30.50 aide hours. Review of the time punch cards for staff on 01/12/26 revealed: -There were 33.75 total aide hours provided on first shift leaving a shortage of 6.25 aide hours. -There were 21.50 total aide hours provided on second shift leaving a shortage of 18.50 aide hours. -There were 14.50 total aide hours provided on third shift leaving a shortage of 17.50 aide hours. Review of the time punch cards for staff on 01/13/26 revealed: -There were 23.50 total aide hours provided on first shift leaving a shortage of 16.50 aide hours. -There were 33.25 total aide hours provided on second shift leaving a shortage of 6.75 aide	{D 465}	10A NCAC 13F Special Care Unit Staff Community ED will assure that community is staffed according to rule .1308 Community held a job fair and hosts open interviews two days a week to promote and assist with staffing needs. Regional Support in serviced ED, Care Coordinators, and BOC on rule .1308 utilizing DHSR "Staffing of Licensed Adult Care Homes" power point. Community has implemented a Manager On Duty (MOD) schedule for weekends to assist in assuring accurate staffing is in place. Regional Support reviewed and trained ED and BOC on reading and understanding of the labor report to ensure SCU is properly SCC Completes Staffing schedules for SCU. ED will review schedules and sign off to assure adequate staffing is available for SCU.	03/22/26 02/10/26 02/11/26 02/17/26 03/11/26 03/22/26

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{D 465}	Continued From page 18 hours. -There were 21.50 total aide hours provided on third shift leaving a shortage of 10.50 aide hours. Review of the time punch cards for staff on 01/14/26 revealed: -There were 29.25 total aide hours provided on first shift leaving a shortage of 10.75 aide hours. -There were 31.50 total aide hours provided on second shift leaving a shortage of 8.50 aide hours. -There were 10 total aide hours provided on third shift leaving a shortage of 22 aide hours. Review of the time punch cards for staff on 01/15/26 revealed: -There were 25.50 total aide hours provided on second shift leaving a shortage of 14.50 aide hours. -There were 6.50 total aide hours provided on third shift leaving a shortage of 25.50 aide hours. Review of the time punch cards for staff on 01/16/26 revealed: -There were 21.50 total aide hours provided on first shift leaving a shortage of 18.50 aide hours. -There were 26.25 total aide hours provided on second shift leaving a shortage of 13.75 aide hours. -There were 26.50 total aide hours provided on third shift leaving a shortage of 5.50 aide hours. Review of the time punch cards for staff on 01/17/26 revealed: -There were 23.75 total aide hours provided on first shift leaving a shortage of 16.25 aide hours. -There were 7.25 total aide hours provided on second shift leaving a shortage of 32.75 aide hours. -There were 26 total aide hours provided on third	{D 465}	CC's and ED will review daily schedule, call outs and staffing at morning stand up to ensure accurate staffing is met. Regional Support will conduct random walk throughs during biweekly visits to ensure staffing is adequate and meets the requirements of rule .1308 for 30 days and weekly thereafter. ED, CC's and/or other designee will conduct multiple daily walk throughs of SCU to ensure staffing requirements are properly met. ED and regional support together will review labor report no less than twice weekly for 30 days to ensure compliance. ED and/or BOC will review timecards daily to assure employees are clocking into correct department. Missed punches to be reviewed at daily stand up with ED.	03/22/26 03/22/26 03/22/26 03/22/26 03/22/26

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{D 465}	Continued From page 19	{D 465}		

shift leaving a shortage of 6 aide hours.

Review of the time punch cards for staff on 01/18/26 revealed:
-There were 17 total aide hours provided on first shift leaving a shortage of 23 aide hours.
-There were 20.50 total aide hours provided on second shift leaving a shortage of 19.50 aide hours.
-There were 19 total aide hours provided on third shift leaving a shortage of 13 aide hours.

Observation of the SCU on 02/06/26 between 8:20am-8:45am revealed:
-3 personal care aides (PCA) and a medication aide (MA) were the only staff members in the SCU.
-The surveyor pulled the call bell at 8:23am from a resident's room.
-A PCA passed the door of the resident room at 8:28am to check on another resident's room that did not have a call bell on.
-The PCA answered the call bell pulled by the surveyor at 8:37am after 14 minutes.

Telephone interview with a resident's responsible party on 02/06/26 at 8:46am revealed:
-The facility was "short staffed a lot" and she had bathed and groomed her family member herself most of the time because staff were not able to manage the workload.
-There were only one or two PCAs in the SCU during the evenings and during the weekends when she visited her family member.

Interview with a PCA on 02/06/26 at 8:05am revealed:
-Most days the SCU was not fully staffed with PCAs and it was difficult for her to cover all the residents' care needs in the unit.

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{D 465}	Continued From page 20	{D 465}		

-She worked first shift and had come to work several times on the weekends and there would not be enough PCAs in the facility for the first, second, and third shifts.
-The Special Care Unit Coordinator (SCUC) and the Resident Care Coordinator (RCC) were supposed to fill in on shifts when "call-outs" occurred or when there was a staff shortage for the SCU but she was not sure if either had filled in as needed.

Interview with a second PCA on 02/06/26 at 8:12am revealed:
-The SCU was short staffed a lot and especially during the weekends.
-There was enough staff on first shift most of the time, but not always enough staff on second and third shift.
-There were times when there were 2 PCAs in the SCU and only one MA.

Interview with a MA on 02/06/26 at 8:17am revealed:
-The facility did not have a full staff on some days and there were times when the SCU had only 2 PCAs to cover the care needs of the SCU residents.
-Some staff would come in late, call out, or not show up because the weekends were short staffed.
-The SCUC and the RCC were supposed to fill in on shifts when "call-outs" occurred or when there was a staff shortage for the SCU.

Interview with the SCUC on 02/06/26 at 9:23am revealed:
-Staffing for the SCU was 4 PCAs and 1 MA for both first and second shifts, and third shift was 3 PCAs and 1 MA.
-There were times they had a lot of "call-outs".

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-Sometimes the staff called the SCUC or the RCC to let them know when there were call-outs, but not every time.
-When she was aware of the call-outs, she would try to find another staff member to come in.

Interview with the RCC on 02/06/26 at 9:45am revealed:
-Both she and the SCUC were responsible for covering staff shortages.
-She encouraged staff to find their own coverage but would fill in if coverage could not be obtained.
-She was aware of staffing shortages in the SCU within previous weeks but there were a lot of "call-outs" by staff.
-Sometimes the staff called the SCUC or the RCC to let them know when there were call-outs, but not every time.

Interview with the Administrator on 02/06/26 at 10:02am revealed:
-The SCUC and the RCC were responsible for scheduling PCAs to ensure there was enough staff for the SCU.
-She had noticed the SCU was short-staffed but they had been working on staffing since her arrival on 01/28/26 due to high staff turnover issues.
-She expected the SCU to be staffed according to regulations and to accommodate the personal care needs of the residents.

The facility failed to ensure the minimum number of staff were present at all times on all three shifts to meet the needs of residents residing in the SCU for 25 of 27 shifts sampled over 9 days from 01/10/26 to 01/18/26. The facility's failure to provide sufficient staffing in the SCU was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated Type B

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{D 465}	Continued From page 22 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/06/26.	{D 465}		