STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068034	A. BUILDING: _____ B. WING _____	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADORABLE SENIOR LIVING	401 WEST QUEEN STREET HILLSBORO, NC 27278

(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 and the Orange County Department of Social Services conducted an annual survey on 11/25/25.	D 000		
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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#2) including administration of correct units of insulin using a sliding scale based on blood sugar (BS) levels. The findings are: Review of Resident #2's current FL-2 dated 09/24/25 revealed diagnoses included type 2 diabetes mellitus, chronic systolic heart failure, history of stoke, visual dementia, anemia and hypertension. Review of Resident #2's signed physician's order dated 09/25/25 revealed: -There was an order for a continuous blood glucose sensor to check BS and replace every 15 days. -There was an order for Novolog (a rapid-acting	D 358	10 A NCAC 13F. 1004(a) Medication Administration The administrator of the Facility conducted a eMAR audit at the end of October 2025 and discovered that the correct units of insulin using a sliding scale base on blood sugar (BS) levels were not properly administered during a 3 day period. She immediately conducted a training for all of the Medication Aides (MA) on insulin admnistration and paremeters. Following the survey conducted on 11-25-202525, additional refresher training was done 11-30-2025. Henceforth, all Medication Aides are adminustering Insulin using the correct sliding scale based on blood sugar (BS) levels.	11-30-2025

"Reviewed and Acknowledged" 02/03/2026 CPP

Division of Health Service Regulation

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D 358	Continued From page 1 insulin used to treat high blood sugar levels) Flex Pen 100 units/ml inject 5 units three times a day before meals, and add additional units for blood sugar values per sliding scale insulin (SSI) parameters: BS 150-200 = add 2 units, 201-300 = add 4 units, 301-400 = add 6 units and >401 = add 8 units. Review of Resident #2's October 2025 electronic medication administration record (eMAR) from 10/09/25 through 10/31/25 revealed: -There was an entry to check BS three times a day before meals scheduled at 7:30am, 11:30am, and 4:30pm. -There was an entry for Novolog Flex Pen 100 units/ml inject 5 units three times a day before meals, and add additional units for BS values per SSI parameters: BS 150-200 = add 2 units, 201-300 = add 4 units, 301-400 = add 6 units and >401 = add 8 units. -The eMAR had a space for documentation of the BS, a time of administration and a space for documenting the amount of Novolog administered. -The incorrect amount of Novolog insulin was administered for three days from 10/11/25 through 10/14/25 with examples as follows: -On 10/11/25 at 4:10 pm, BS was 153 and 7 units of Novolog should have been administered but 9 units of Novolog were documented as administered on the eMAR. -On 10/12/25 at 7:50 am, BS was 194 and 7 units of Novolog should have been administered but 10 units of Novolog were documented as administered on the eMAR. -On 10/13/25 at 11:30 am, BS was 136 and 5 units of Novolog should have been administered but 10 units of Novolog were documented as administered on the eMAR.	D 358	The administrator will continue to monitor and audit eMar to ensure compliance.	

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D 358	Continued From page 2 Interview with Resident #2's primary care provider (PCP) on 11/25/25 at 2:51 pm revealed: -She was aware Resident #2 was on insulin with sliding scale parameters. -She was not aware insulin was administered incorrectly for three days in October. -The BS levels would fluctuate if the amount of insulin was not administered correctly. -She was not aware of Resident #2 having any hypoglycemia or hyperglycemia levels in October 2025. -She would expect the insulin to be administered as ordered. Interview with a medication aide (MA) on 11/25/25 at 3:00 pm revealed: -She had administered Resident #2's Novolog insulin three times a day and adjusted the units if the BS was over 150. -She was aware some MAs were not used to using the sliding scale for Resident #2. -The Administrator trained all MAs on the sliding scale in October 2025. -She was unsure of the exact date of the training. Interview with the Administrator on 11/25/25 at 3:15pm revealed: -She was aware there were errors in the amount of insulin that was administered in the beginning of October 2025. -When she saw the errors, she immediately did a training on insulin administration and parameters with all the MAs. -She was responsible for eMAR audits. -She expected MAs to administer the correct amount of Novolog using the parameters as written in the order. Based on observations, record reviews and interviews, it was determined Resident #2 was	D 358		

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D 358	Continued From page 3 not interviewable.	D 358		