STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017040	A. BUILDING: _____ B. WING _____	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
G ANTHONY RUCKER REST HOME	1196 HODGES DAIRY ROAD YANCEYVILLE, NC 27379

(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 an annual survey on 12/30/25 to 12/31/25.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to contact the primary care provider (PCP) for 1 of 3 sampled residents (#2) related to elevated blood sugar levels. The findings are: Review of Resident #2's FL2 dated 08/14/25 revealed: -Diagnoses included type 2 diabetes. -The was an order for finger stick blood sugars (FSBS) four times daily before meals and at bedtime. Review of Resident #2's physician's orders dated 08/14/25 revealed there was an order to follow sliding scale order and if FSBS was higher than 251 give 30 units of insulin, wait 30 minutes and recheck FSBS; if results were still 251 or higher to notify the PCP even if after hours. Review of Resident #2's physician's order dated 09/30/25 revealed: -There was an order for FSBS four times daily. -If FSBS was higher than 251 give 30 units of insulin, wait 30 minutes and recheck FSBS; if results were still 251 or higher to notify the PCP	D 273	Administrator will assure to get a order that clarify Blood Sugar peameters. Administrator has already got an order for resident #2 elevated blood sugar levels the Clarification for the elevated and blood sugars are in resident file. *Order is also attached to this plan of correction* Administrator will check the resident records every other week for one month. PD 03/03/26	1/5/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: G. Anthony Rucker Sr. | TITLE: Administrator/owner | (X6) DATE: 2/16/26

Revised via telephone with the Administrator on 03/03/26. PD

Reveiwed and acknowledged 03/03/26

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D 273	Continued From page 1 even if after hours. Review of Resident #2's October 2025 medication administration record (MAR) revealed: -There was an entry for FSBS checks four times daily scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm. -There was documentation Resident #2's FSBS were completed four times daily but there were no FSBS results documented on the entry. -There was a second entry to check FSBS three times daily before meals with a sliding scale insulin order and if FSBS was higher than 251 give 30 units of insulin, wait 30 minutes and recheck FSBS, if results were still 251 or higher to notify the PCP even after hours. -There was documentation Resident #2's FSBS was completed three times daily but there were no FSBS results documented on the entry. Review of Resident #2's FSBS logs for October 2025 revealed: -There were eight hand drawn columns on pieces of lined notebook paper with Resident #2's name across the top. -The columns were titled date, time, reading, sliding scale, injection site, amount given, type of insulin used and staff initials. -There were handwritten instructions to check FSBS four times daily before meals and administer insulin per the sliding scale and to administer a long-acting insulin at bedtime. -Resident #2's FSBS results were over 251 three times from 10/01/25 to 10/31/25. -There was no documentation Resident #2's endocrinologist or primary care provider (PCP) was notified. Review of Resident #2's November 2025 MAR revealed:	D 273		

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D 273	Continued From page 2 -There was an entry for FSBS checks four times daily scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm. -There was documentation Resident #2's FSBS was completed four times daily but there were no FSBS results documented on the entry. -There was a second entry to check FSBS three times daily before meals with a sliding scale insulin order and if FSBS was higher than 251 give 30 units of insulin, wait 30 minutes and recheck FSBS, if results were still 251 or higher to notify the PCP even after hours. -There was documentation Resident #2's FSBS was completed three times daily but there were no FSBS results documented on the entry. Review of Resident #2's FSBS logs for November 2025 revealed: -There were eight hand drawn columns on pieces of lined notebook paper with Resident #2's name across the top. -The columns were titled date, time, reading, sliding scale, injection site, amount given, type of insulin used and staff initials. -There were handwritten instructions to check FSBS four times daily before meals and administer insulin per the sliding scale and to administer a long-acting insulin at bedtime. -Resident #2's FSBS results were over 251 eight times from 11/01/25 to 11/30/25. -There was no documentation Resident #2's endocrinologist or primary care provider (PCP) was notified. Review of Resident #2's December 2025 MAR revealed: -There was an entry for FSBS checks four times daily scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm. -There was documentation Resident #2's FSBS	D 273		

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D 273	Continued From page 3 was completed four times daily but there were no FSBS results documented on the entry. -There was a second entry to check FSBS three times daily before meals with a sliding scale insulin order and if FSBS was higher than 251 give 30 units of insulin, wait 30 minutes and recheck FSBS, if results were still 251 or higher to notify the PCP even after hours. -There was documentation Resident #2's FSBS was completed three times daily but there were no FSBS results documented on the entry. Review of Resident #2's FSBS logs for December 2025 revealed: -There were eight hand drawn columns on pieces of lined notebook paper with Resident #2's name across the top. -The columns were titled date, time, reading, sliding scale, injection site, amount given, type of insulin used and staff initials. -There were handwritten instructions to check FSBS four times daily before meals and administer insulin per the sliding scale and to administer a long-acting insulin at bedtime. -Resident #2's FSBS results were over 251 six times from 12/01/25 to 12/31/25. -There was no documentation Resident #2's endocrinologist or primary care provider (PCP) was notified. Telephone interview with a clinical nurse from Resident #2's endocrinologist office on 12/31/25 at 9:06am revealed: -The endocrinologist had not been notified of Resident #2's FSBS being 251 or higher any time in October 2025, November 2025 or December 2025. -If the facility staff had notified the endocrinologist of Resident #2's FSBS results were 251 or higher at the time the amount of insulin administered	D 273		

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D 273	Continued From page 4 might have adjusted. -The facility staff failed to bring Resident #2's MARs with her on visits so there was no way to determine what was administered. Interview with the medication aide (MA) on 12/31/25 at 10:54am revealed: -When Resident #2's FSBS results were 251 or more she administered 30 units of insulin and then did a recheck. -If Resident #2's FSBS was still 251 or higher she would give her ice water to drink to flush her kidney and document the results. -She did nothing else after she gave Resident #2 water because there were no other instructions on the order. -She always called the Administrator when she had to recheck Resident #2's FSBS. -She did not document the telephone call to the Administrator anywhere. -She would watch Resident #2 to see if she was okay, if she went to the bathroom, if she was sweaty or if she became sleepy. -She did not call the PCP or the endocrinologist. Interview with the Administrator on 12/31/25 at 1:32pm revealed: -He called the physician when there was a reason to contact them. -The MA would call him, and he would call the physician. -He knew the order to call the physician was when the FSBS were still above 251 at the second FSBS check. -He had not had to call the physician for Resident #2's FSBS results over 251 because when she was administered the 30 units of insulin it would lower the FSBS. -He had not reviewed the FSBS logs in a while. -He was not aware her FSBS remained over 251	D 273		

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D 273	Continued From page 5 at the second FSBS check because the MA did not call him. Based on observations, interviews and record reviews it was determined Resident #2 was not interviewable.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) Facilities with a licensed capacity of 7 to 12 residents shall ensure food services comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure all food items stored and prepared by the facility were served under sanitary conditions related to expired food and a food container that was not properly labeled. The findings are: Review of the Environmental Health Services	D 282	Adminstrator will once a week when groceries are purchased for one month for out of date products. 01/05/26 Administrator removed all can goods and expired food the morning of the survey. All can goods and food that was expired was removed while Surveyor was there at facility. All #10 cans that was dented and rusted was removed immediately the morning of survey. 12/31/25 12/31/25	

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D 282	Continued From page 6 inspection report dated 08/12/25 revealed: -The facility sanitation score was an A and they received 6 demerits. -There were three demerits for the sanitation for the kitchen in the large can storage area, in in the other dry storage areas. -There were three demerits for the observation of evidence of pest in the kitchen. Observation of the facility's dry storage on 12/30/25 at 8:30am revealed: -There was an open jar with one third of peanut butter in it with a use by date of October 2023. -There were two unopened bags of grits with the use by dates of 11/30/25 and 01/12/25. -There was a box of macaroni and cheese with a use by date of 11/12/25. -There were three, number 10 sized cans (large cans of food with 23 to 25 servings) of pears that were budging on the top and the bottom of the cans stored in a cabinet. -There was a number 10 can of collard greens that had a deep dent on the side of the can. -There was a number 10 can of apples that was dented and rusted. -There were two number 10 cans of mixed vegetables with dents on the side of the cans. -There was a number 10 can of mandarin oranges with a dent on the side and bottom of the can, the label had water marks on it from where the can had leaked. -There were two number 10 cans of baked beans with large dents on the side of the cans. -There was a large can of tuna with a dent in the side of the can. -There was a number 10 can of peaches that was dented and had leaked. Interview with the cook on 12/31/25 at 12:38pm revealed:	D 282		

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D 282	Continued From page 7 -He was not required to do inspections in the kitchen. -If he saw something like an expired or out of date food he would discard it. -He would let the Supervisor-in-Charge (SIC) know if he saw mold or expired and out of date food. -He had never used one of the number 10 cans before, so he had not seen the dented cans. -He had not seen the expired jar of peanut butter. Interview with the SIC on 12/30/25 at 11:58am revealed: -She was supposed to inspect the kitchen once a month. -She looked for expired foods and checked the canned foods for damage. -She checked the canned foods to see if they had leaked, had a label, and to make sure they had not expired. -At one time the number 10 cans had been in a cabinet in the corner of the dining room. -The shelves in the cabinet fell and she moved the number 10 cans to the dry storage in the kitchen. -She did not know if that was when the cans were damaged. -The last time she had checked the food in the kitchen was in October 2025. -She thought another staff checked the dry storage for expiration dates and damaged canned food in November 2025 and December 2025. Interview with the Administrator on 12/30/25 at 9:55am revealed: -He purchased food once a week. -The staff were supposed to check for expired food and throw it out once it expired. -The staff checked the kitchen and food for	D 282		

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D 282	Continued From page 8 dented cans once a month. -The staff were supposed to throw out any expired food. -The staff should have noticed the condition of the cans, and they should have discarded them. -The staff knew if the cans had expired, were dirty, had leaked, or were dented they were to be removed. -He did not inspect the kitchen. -He had purchased the number 10 cans for emergency use about six months to one year ago. -He was concerned there were dented and bulging cans in the dry storage he would have to check the dry storage himself.	D 282		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure mealtime table included a place setting consisting of a knife, fork, and spoon.	D 286		

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D 286	Continued From page 9 The findings are: Observation of the Lunch meal on 12/30/25 from 11:50am to 12:30pm revealed: -There were eleven residents in the dining room. -The tables were preset by the cook, and each place setting had a spoon and a fork. -The residents were served chicken salad sandwiches, potato salad, popcorn, cookies, milk, water and lemonade. -The chicken salad sandwiches were whole. -Some of the residents tore their sandwiches in half and one resident folded his sandwich in half. Interview with a resident on 12/30/25 at 3:50pm revealed: -She only got a spoon and a fork at meals -She never got a knife to use. -She could use a knife herself and there were times she needed a knife. -The staff cut her meat for her but sometimes she wanted the meat cut smaller. -She wanted to cut her meat herself. -She used to cut up her own food if she needed it cut. -She had never asked for a knife because she had not been given a knife since she moved to the facility. Interview with a second resident on 12/31/25 at 10:00am revealed: -She never got a knife with her meal. -She had not asked for a knife because she thought they could not have them; none of the other residents got knives either. -The staff cut her food for her before they brought it to the table. -She would cut her food herself if they gave her a knife.	D 286	Administrator will assure that a knife is included in the table setting. 12/31/25 SIC will monitor the place settings once daily for one month. 01/05/26 PD 03/03/26	

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D 286	Continued From page 10 Interview with the cook on 12/31/25 at 10:25am revealed he was told by the Supervisor-in-Charge (SIC) not to give the residents a knife; he did not know why. Interview with the SIC on 12/31/25 at 10:38am revealed: -The facility staff gave knives to the residents that could use them. -Some of the residents would not know what to do with them. -She cut the meat for the residents that did not get knives. -The cook set the place settings on the table. -She was trained to put the knives on the table for all the residents. -Some of the residents did not have the dexterity to use a knife. -If a resident asked for a knife, she would give them one. Interview with the Administrator on 12/31/25 at 1:32pm revealed: Knives were given to the residents if they requested one. He was told years ago that he did not have to provide knives for the residents to use at meals. He did not know it was a requirement to provide a knife for the residents. The only reason the staff did not provide knives for the residents is because he was told they didn't need them. He would begin to provide knives for the residents to use at mealtimes.	D 286		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service	D 312		

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D 312	Continued From page 11 (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 1 sampled residents (#1) requiring assistance with meals were assisted upon receipt of meals in a manner that was unhurried and preserved dignity and respect. The findings are: Review of Resident #1's current FL-2 dated 09/29/25 revealed diagnoses included mental retardation. Observation of the Lunch meal on 12/30/25 from 11:50am to 12:30pm revealed: -Resident #1 was served a pureed meal. -At 12:08pm, the cook stood to the left and a little behind Resident #1 as he fed him. -At 12:10pm, the cook stopped feeding Resident #1 and went to help another resident. -At 12:11pm, the cook went to the kitchen. -At 12:12pm, the cook began to feed Resident #1 while standing to the resident's left. -At 12:13pm, the cook stopped feeding Resident #1 and answered the facility's telephone and served residents milk. -At 12:15pm, the cook began to feed Resident #1 while standing to the resident's left. -At 12:20pm, the cook went to the kitchen to get seconds for other residents. -At 12:23pm, the cook began to feed Resident #1	D 312	Administrator will assure that Staff understood if another resident(s) is admitted to facility that need assisting with feeding that the Staff understood to sit and do not rush the resident to eat and do not leave resident unattended while feeding. SIC will monitor feeding assistance as need for one month. PD 03/03/26	12/31/25 01/05/26

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D 312	Continued From page 12 while standing to the resident's left. -At 12:27pm, the cook began to clear plates from tables. -At 12:29pm, the Supervisor-in-Charge (SIC) began to feed Resident #1 while she was seated. Interview with Resident #1 on 12/30/25 at 12:50pm revealed: -He had fallen and went to the hospital. -He thought he fell sometime last week. -He could not use his right arm before he went to the hospital. -He could not use his left arm since he fell because it hurt to move it. -Staff helped him eat because it hurt to use his left arm. Interview with the cook on 12/30/25 at 12:38pm revealed: -He had not been trained in how to provide feeding assistance to a resident since he had started at the facility. -He already knew how to provide feeding assistance for residents from his previous job. -He knew not to feed Resident #1 certain foods like popcorn. -Resident #1 had been fed by staff since he stopped using his left arm to feed himself. -Resident #1 had never used his right arm because it was damaged from a prior injury. -He had been helping feed Resident #1 for about a month. -Resident #1 went to the hospital and when he returned, he required feeding assistance. -He was in the dining room by himself and had to assist other residents when they requested something. Interview with the SIC on 12/31/25 at 12:48am revealed:	D 312		

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	HAL017040	A. BUILDING: _____ B. WING _____	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
G ANTHONY RUCKER REST HOME	1196 HODGES DAIRY ROAD YANCEYVILLE, NC 27379

(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 312	Continued From page 13 -She had been feeding Resident #1 since he fell a week ago. -He used to feed himself but then he returned from the hospital, and he was not using his left arm. -She had been trained on how to feed a resident, but it had been so long ago she did not remember who trained her or when she was trained. -She knew to let the resident chew and swallow before she gave them another bite of food. -After every two bytes she offered water. -She or the cook would feed Resident #1. -Whoever started feeding was supposed to finish feeding. -She knew staff were not supposed to get up and walk around because the resident could lose their appetite or stop eating if staff stopped feeding and were walking around. -She finished feeding Resident #1 yesterday, 12/30/25, because the cook was behind. -Most of the time she sat and fed Resident #1 herself. -She knew staff were supposed to sit next to the resident while providing feeding assistance because if staff stand the resident must look up while eating. -She had told the cook how to feed Resident #1 including to sit while feeding and not getting up once he started. Interview with the Administrator on 12/30/25 at 4:30pm revealed: -Resident #1 fell and was in the hospital for a few days. -When he returned, the staff noticed he was not using his left arm. -He did not complain of pain. -On 12/29/25 the facility took him to the local emergency department (ED) and had x-rays done of his left arm.	D 312		

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D 312	Continued From page 14 -His arm was not broken. -The physician at the ED said he had a muscle strain or soreness. -Resident #1 had an appointment with his primary care provider (PCP) on 12/31/25 to see if he needed physical therapy. Telephone interview with the Administrator on 12/31/25 at 1:35pm revealed: -Resident #1 had been fed by the staff since his fall. -Any staff available including the cook and the SIC were supposed to assist Resident #1 with feeding. -All the staff had been trained in feeding technique. -Per training the staff were supposed to give two to three bites and then offer a drink. -The staff were supposed to sit and not stand while providing feeding assistance. -The staff were required to sit with the resident the entire meal. -The staff were supposed to encourage the resident to eat slowly, to chew and to swallow. -The staff was not supposed to walk away because the resident could lose their appetite if the staff walked away. -They should not switch in the middle of feeding a resident, he had instructed them to stay with the resident.	D 312		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the	D 344		

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D 344	Continued From page 15 resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to clarify medication orders for 1 of 3 sampled residents (#2) related to orders to a sliding scale insulin and glucose tablets with the sliding scale. The findings are: Review of Resident #2's FL2 dated 08/14/25 revealed: -Diagnoses included type 2 diabetes. -The was an order for finger stick blood sugars (FSBS) four times daily before meals and at bedtime. -There was an order for sliding scale insulin three times a day for FSBS results between 70-150 give 15 units of Novolog insulin (used to control blood sugar); if FSBS results were 70 or below give three glucose tablets, wait 15 minutes, repeat FSBS and give another three tablets if FSBS remains less than 70. Review of Resident #2's physician's order dated 09/30/25 revealed: -There was an order for FSBS four times daily. -There was an order for sliding scale insulin three times daily, give 15 units of Novolog for FSBS results between 70 -150. -There was an order for glucose (used to treat	D 344	Administrator will assure that order is clarified stating about glucose tables and Sliding scale Administrator has already got order for resident and glucose tables. Order is in resident file *Order is attached to this plan of correction. Administrator will check the resident records every other week for one month. 01/05/26 PD 03/03/26	1/5/26

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D 344	Continued From page 16 low blood sugar levels) 4gm if FSBS results were 70 or below give three glucose tablets, wait 15 minutes, repeat FSBS and give another three tablets if FSBS remains less than 70. Review of Resident #2's October 2025 medication administration record (MAR) revealed: -There was an entry to check FSBS three times daily before meals scheduled at 8:00am, 12:00pm and 5:00pm with a sliding scale insulin order for results 70-150 administer 15 units of Novolog. -There was documentation Resident #2's FSBS was completed three times daily but there were no FSBS results documented on the entry. -There was a second entry for glucose 4gm take three tablets as needed if blood sugar is 70 or below, recheck FSBS after 15 minutes and repeat does if FSBS remains less than 70. -Glucose was not documented as administered on the MAR from 10/01/25 to 10/31/25. Review of Resident #2's FSBS logs for October 2025 revealed: -There were eight hand drawn columns on pieces of lined notebook paper with Resident #2's name across the top. -The columns were titled date, time, reading, sliding scale, injection site, amount given, type of insulin used and staff initials. -There were handwritten instructions to check FSBS four times daily before meals and administer insulin per the sliding scale and to administer a long-acting insulin at bedtime. -On 10/04/25, at 5:16pm, Resident #2's FSBS was 65, glucose was administered and at 5:30pm her FSBS result was 86; 15 units of Novolog were documented as administered after the second FSBS check. -On 10/06/25, at 5:12pm, Resident #2's FSBS	D 344		

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D 344	Continued From page 17 was 65, glucose was administered and at 5:33pm her FSBS result was 86; 15 units of Novolog were documented as administered after the second FSBS check. -On 10/09/25, at 5:47pm, Resident #2's FSBS was 61, glucose was administered and at 6:04pm her FSBS result was 85; 15 units of Novolog were documented as administered after the second FSBS check. Review of Resident #2's November 2025 MAR revealed: -There was an entry to check FSBS three times daily before meals scheduled at 8:00am, 12:00pm and 5:00pm with a sliding scale insulin order for results 70-150 administer 15 units of Novolog. -There was documentation Resident #2's FSBS was completed three times daily but there were no FSBS results documented on the entry. -There was a second entry for glucose 4gm take three tablets as needed if blood sugar is 70 or below, recheck FSBS after 15 minutes and repeat does if FSBS remains less than 70. -Glucose was not documented as administered on the MAR from 11/01/25 to 11/30/25. Review of Resident #2's FSBS logs for November 2025 revealed: -There were eight hand drawn columns on pieces of lined notebook paper with Resident #2's name across the top. -The columns were titled date, time, reading, sliding scale, injection site, amount given, type of insulin used and staff initials. -There were handwritten instructions to check FSBS four times daily before meals and administer insulin per the sliding scale and to administer a long-acting insulin at bedtime. -On 11/03/25, at 6:38pm, Resident #2's FSBS	D 344		

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D 344	Continued From page 18 was 64, glucose was administered and at 7:06pm her FSBS result was 81; 15 units of Novolog were documented as administered after the second FSBS check. -On 11/19/25, at 12:28pm, Resident #2's FSBS was 57, glucose was administered and at 1:05pm her FSBS result was 96; 15 units of Novolog were documented as administered after the second FSBS check. Telephone interview with a clinical nurse from Resident #2's endocrinologist office on 12/31/25 at 9:06am revealed: -Staff from the facility called the endocrinologist on 08/27/25 to clarify the order for the glucose tablets. -The facility staff wanted to know if they were supposed to administer Resident #2 any insulin if the glucose tablets raised the FSBS between 70-150. -The endocrinologist wanted clarification from the facility staff on the type of glucose they were administering to determine if it was over the counter (OTC). -The clinical nurse called the facility on 08/27/25 and left a message but no one ever returned the call. -She could not say if Resident #1 should receive the f 15 units of insulin or not. -Typically, additional units of insulin would not be administered because it would lower Resident #1's FSBS again. -The endocrinologist office had requested the facility provide MARs at Resident #1's visits but they failed to bring them with them; they could have reviewed the MAR and clarified the order at a visit if they had the MAR. -The order was never considered clarified. Interview with the medication aide (MA) on	D 344		

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D 344	Continued From page 19 12/31/25 at 10:54am revealed: -When Resident #2's FSBS was 70 or less she gave the resident three glucose tablets and would wait 30 minutes and recheck the FSBS. -If resident number twos FSBS went above 70 on the recheck she did not administer any insulin because her FSBS would go back down. -There were no instructions in the order on the MAR to administer any insulin after the recheck, so she did not give. -If she had documented on the FSBS log that she administered 15 units of insulin after administering glucose it was a documentation error because she never administered insulin for FSBS results after administering glucose tablets. -Because she documented 15 units of insulin on the FSBS log it looked like she administered it to Resident #2 even if she did not. -She would have to pay more attention to what she was documenting on the FSBS log when it came to Resident #2's sliding scale insulin and rechecks. Interview with the Administrator on 12/31/25 at 1:32pm revealed: -He called the physician when an order needed to be clarified. -He was not aware the order for the sliding scale insulin needed to be clarified. -He knew Resident #2 had an order for glucose tablets when her FSBS was below 70. -The MA must have documented the administration of 15units of insulin by mistake, but the order still needed to be clarified. Based on observations, interviews and record reviews it was determined Resident #2 was not interviewable.	D 344		