STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225577	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Notre Dame Long Term Care Center	559 Plantation Street Worcester, MA 01605

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, and interviews, the facility failed to ensure staff stored and labeled all drugs and biologicals in accordance with accepted professional standards of practice, as required, for two (Cuvilly Unit High Side and Cuvilly Unit Low Side) of the three medication carts reviewed.Specifically, for the Cuvilly Unit High Side medication cart and the Cuvilly Unit Low Side medication cart, the facility failed to ensure that medications were appropriately stored and labeled in the two medication carts when loose, unlabeled pills were observed in both medication carts. Findings include:Review of the facility policy titled Medication Cart Cleaning, dated December 2023, included:-All Medication Carts will be cleaned and organized weekly on the 11-7 shift On 5/6/26 at 8:20 A.M., the surveyor and Unit Manager (UM) #3 observed in the Cuvilly Unit High Side medication cart thirty-five loose pills, paper remnants and elastics, as well as powder in the corners of the drawer that holds resident specific medication cards. During an interview at the time, UM #3 said the concern would be that the loose medications could have been dropped by the Nurse leading to an omission of prescribed medications. UM #3 said her expectation was that the medication carts would be clean and free of loose medications and debris. UM #3 said it was the day-to-day responsibility of the Nurse assigned to the medication cart to keep the cart clean but, ultimately, as the manager, it was her responsibility to ensure that the carts were clean. On 5/6/26 at 9:20 A.M., the surveyor and Nurse #4 observed in the Cuvilly Unit Low Side medication cart fifty loose pills, paper remnants, and elastics, as well as powder in the corners of the drawer that holds resident specific medication cards. During an interview at the time, Nurse #4 said she would need to ask UM #3 who was responsible for ensuring that the medication cart was clean and free of debris, as she was unsure. During an interview, on 5/6/26 at 4:57 P.M., the Director of Nursing (DON) said it was his expectation that the medication carts were clean. The DON said that it was the responsibility of the Nurse assigned to the cart to clean the cart at the end of their shift.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that a person-centered care plan, relative to eating assistance and supervision, was implemented for one Resident (#12) out of a total sample of 24 residents. Specifically, for Resident #12, the facility failed to implement supervision by one staff and assist of one staff as needed to set up meals as required, when the Resident experienced a significant weight decline and was care planned for feeding assistance and supervision.Findings include:Review of the facility policy titled Meal Serving, revised February 2012, included but was not limited to:*All residents able to receive oral feeding are properly positioned to facilitate eating. Any resident requiring assistance with meals receives help as needed. Adaptive equipment is provided as ordered to assist individual residents as needed.-Residents who are able to eat outside of their rooms are served in the dining areas.-Residents incapable of feeding themselves will be assisted by trained staff. Review of the facility policy titled Nutritional Assessment, revised October 2017, included but was not limited to:*As part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident.-The dietician, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission (within current baseline assessment timeframes) and as indicated by a change in condition that places the resident at risk for impaired nutrition.-As part of the comprehensive assessment, the nutritional assessment will be a systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk or with impaired nutrition.-Once current conditions and risk factors for impaired nutrition are assessed and analyzed, individual care plans will be developed that address or minimize to the extent possible the resident's risks for nutritional complications. Such interventions will be developed within the context of the resident's prognosis and personal preferences. -Individual care plans shall address to the extent possible:>Goals and benchmarks for improvement. Review of the facility policy titled Change in a Resident's Condition or Status, revised December 2025, included but was not limited to:*The facility promptly notifies the resident, resident's attending physician or provider, and the resident representative of changes in the resident's condition and/or status.-A significant change of condition is a major decline or improvement in the resident's status that:>Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical intervention (is not self-limiting).>Requires interdisciplinary review and/or revision to the care plan. Resident #12 was admitted to the facility in November 2025 with diagnoses including moderate protein calorie malnutrition, Dysphagia, Hypothyroidism, and Hypo-Osmolality and Hyponatremia. Review of Resident #12's Weight Summary from 11/12/25 (weight 106.1 pounds [lbs.]) through 5/5/26 (weight 88.8 lbs.) indicated a significant weight loss of 16.31 percent (%) over a six-month period. Review of Resident #12's Speech Care Plan, revised 11/14/25, indicated:-the Resident had a swallowing problem related to swallowing assessment results.>Check mouth after each meal for pocketed food and debris.>Resident to eat only with supervision. Review of Resident #12's Nutritional Risk assessment dated [DATE], indicated: *Swallowing Disorder Data:>Swallowing disorder indicated.>Holding food in mouth/cheeks or residual food in mouth after meals.>Coughing or choking during meals or when swallowing medications.*Physical and Functional Data:>Independent.>Setup assistance and supervision. Review of Resident #12's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident:-was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of six out of 15 -was holding food in mouth and cheeks or residual food in mouth after meals-had weight loss-required a mechanically altered diet and required change in texture of food or liquids-required set up and assistance with eating Review of Resident #12's Activity of Daily Living (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(ADL) Care Plan, revised 3/21/26, indicated:-the Resident had an ADL self-care performance deficit related to weakness, fractures, and decreased activity tolerance. >eating: the Resident required a setup and assistance as needed. Supervised for meals. Review of Resident #12's Dietician Progress Note dated 4/14/26, indicated: -Reweight obtained 90.1 lbs. (4/9/26) and remains low.-Reflects an 8.2 percent (%) significant weight loss x (times) one month and 12.6% significant weight loss x six months. Review of Resident #12's Kardex Report (summary of Resident's daily care needs, including eating), dated 5/7/26, included but was not limited to:>check mouth after meal for pocketed food and debris.>set-up and assist as needed.>supervised for meals.>Resident to eat only with supervision. Review of Resident #12's May 2026 Physician's orders, indicated:-Regular diet pureed texture, thin consistency, fermentable oligosaccharides, disaccharides, monosaccharides and polyols (FODMAP) DIET (certain sugars that may cause intestinal distress), No Straws, Supervised dining all meals, initiated 11/11/25.-OWYN non-dairy protein shake, vanilla flavor 330 milliters (ml) by mouth (PO) three times a day (TID) (daughter will bring in shakes) with meals for supplement, initiated 4/8/26. Review of Resident #12's Alteration in Nutrition Care Plan interventions, revised 5/6/26, indicated:>Dysphagia>Weight loss>Underweight body mass index -18.5 (BMI- a screening tool that uses a person's height and wight to estimate the amount of body fat)>Ongoing supervision at meals/encouragement and assistance when ableOn 5/6/26 at 9:05 A.M., the surveyor observed a staff member entering Resident #12's room and alerted the Resident that the breakfast meal was ready. The surveyor further observed the staff member place the breakfast meal on a bedside table and elevated the Resident's head of the bed, set the meal up for the Resident and exited the room. On 5/6/26 at 9:16 A.M., the surveyor observed Resident #12 seated on his/her bed in his/her bedroom with the head of the bed elevated and a bedside table in front of the Resident with a breakfast meal. The meal included a bowl of gluten free oatmeal, pureed pancake with syrup, pureed eggs and two nosey cups (an adaptive drinking aid featuring a U-shaped cutout on one side, the cutout provides space for the nose, allowing individuals to drink without tilting their head back or extending their neck) containing Lactaid milk. Resident #12 was observed with a clothing protector around his/her chest area and was eating the breakfast meal. Resident #12 spilled most of the oatmeal on his/her clothing during the meal. Resident #12 was observed to pick up the nosey cup and place the notched side of the cup to his/her mouth, spilled the drink on his/her clothing and placed the nosey cup back on his/her meal tray. The surveyor did not observe any staff members returning to the room to assist after the breakfast meal was set up for the Resident. On 5/6/26 at 9:38 A.M., the surveyor observed Resident #12 lying in his/her bedroom with the head of the bed elevated and the breakfast meal on a bedside table. The pureed pancake and pureed eggs were observed to be untouched by the Resident. The surveyor observed the Resident picking up the nosey cup, placed the notched side of the cup to his/her mouth and spill the drink on his/her clothing. Resident #12 was observed moaning and placed the cup on his/her tray. The surveyor did not observe a staff member present in the room with the Resident. On 5/7/26 at 8:40 A.M., the surveyor observed Nurse #2 enter the Resident's room with the breakfast meal. Nurse #2 placed the breakfast meal on a bedside table and alerted the Resident that the breakfast meal was ready. Nurse #2 elevated the head of the bed for the Resident, positioned the meal tray in front of the Resident and then exited the room. On 5/7/26 at 8:48 A.M. through to 9:15 A.M., the surveyor observed the Resident's room for the reminder of the mealtime and did not observe any staff members entering the room. The Resident was observed seated on his/her bed with the head of the bed elevated and a breakfast meal on a bedside table in front of the Resident. The meal included pureed scrambled eggs, gluten free pureed muffin with syrup in a lip plate, gluten free oatmeal, Owyn shake, and two nosey cups each containing Lactaid milk. Resident #12 was observed to pick up a black handled spoon to eat his/her breakfast meal and spill the oatmeal and pureed scrambled eggs on his/her clothing. The surveyor observed the gluten free pureed muffin and pureed scrambled eggs remained untouched by the Resident and the gluten free oatmeal spilled on the Resident's clothing. During an interview on 5/7/26 at 9:29 A.M., CNA #2 said that Resident #12 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required supervision during meals. CNA #2 said that supervision indicated that a staff member must be present during meals to supervise the Resident. CNA #2 said that the risk for Resident #12 not being supervised during his/her breakfast meal was the risk of choking. During an interview on 5/7/26 at 9:31 A.M., Unit Manager (UM) #1 said that Resident #12 required supervision during meals and a staff member should have been in the room supervising the Resident during the breakfast meal. UM #1 said that Resident #12 had weight loss and supervising the Resident during meals ensures that the Resident consumed his/her meals to prevent additional weight decline and nutritional deficiencies. During an interview on 5/7/26 at 3:13 P.M., the Speech Therapist (ST) said that she evaluated Resident #12 to determine if the Resident's diet could be upgraded to a different meal texture as a request by the Health Care Proxy (HCP- the person chosen as the healthcare decision maker when the individual is unable to do so for themself). The ST said Resident #12 was evaluated with ground textured meals, but the Resident was unable to swallow the food. The ST said she recommended that Resident #12 stay on a pureed textured diet with supervision for encouragement. The ST said that Resident #12 would benefit from staff encouragement and supervision with meals. During an interview on 5/7/26 at 3:30 P.M., the Registered Dietician (RD) said Resident #12 was referred to her due to significant weight loss and request for a speech evaluation. The RD said she did meal rounds and observed that on several occasions Resident #12's head was down and he/she was not touching his/her food during meals. The RD said that she updated Resident #12's care plan to include supervision with meals because the Resident was eating his/her meals in the dining room and expected staff members to be present with the Resident during meals. The RD said that she was not aware that Resident #12 was eating his/her meals in his/her bedroom. The RD further said that Resident #12 should have been provided with supervision for risk of additional weight decline and nutritional deficiencies. During an interview on 5/8/26 at 7:20 A.M., the Staff Development Coordinator (SDC) said all newly hired CNA's were paired with seasoned CNA's for training on all floors and were given a check list to complete during the orientation process. The SDC said that all CNA's should review the resident's Kardex every day prior to providing resident care to determine each resident care needs. The SDC said that if Resident #12's Kardex indicated supervision with meals, the CNA should be in the room with the Resident to provide supervision. The SDC said that the risk to Resident #12 not being provided with supervision during meals would be aspiration.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observations, interviews, and record review, the facility failed to ensure that medications were administered per professional standards of practice for two Residents (#90 and #104) out of a total sample of 24 residents, resulting in two significant medication errors. Specifically, 1.for Resident #90, the facility staff failed to obtain a blood pressure reading per the Physician's order, prior to administering Amlodipine Besylate (medication used to treat high blood pressure) and to hold (not give) the Amlodipine Besylate medication for a Systolic Blood Pressure (SBP- top number of a blood pressure reading) that measured less than 110 millimeters of Mercury (mmHg) in accordance with the Physician's order, placing the Resident at risk for cardiac compromise, hypotension (extremely low blood pressure) and related complications such as dizziness, fainting and vision changes. 2.for Resident #104, the facility staff failed to hold Amlodipine Besylate, Torsemide (diuretic medication used to treat fluid retention and high blood pressure), and Valsartan (medication used to treat high blood pressure, heart failure, and to improve survival after a heart attack) in accordance with the Physician's order to hold the medications for a SBP that measured less than and/or equal to 105 mmHg and Diastolic Blood Pressure (DBP- bottom number in a blood pressure reading) that measured less than and or equal to 60 mmHg, placing the resident at risk for cardiac compromise such as dizziness, lightheadedness and fainting. Findings include: Review of the facility policy titled Vital Signs and Weight, revised 8/00, included but was not limited to:*Vital signs of residents are monitored regularly.-It is the policy of the facility to monitor vital signs on a regular basis to ensure maximum health and well being of the residents.>Pulse and blood pressure are taken on all residents on admission, monthly, as ordered, and when needed.>The charge nurse is responsible for comparing the current vital signs and weight with the previous results and for taking appropriate action when variances are noted.>Nursing judgment must be used when resident health status changes (e.g., symptoms of congestive heart failure). These residents have vital signs monitored more frequently as a nursing measure. Physicians are notified of significant changes. >Resident care plans are updated as needed. Review of the facility policy titled Administering Medications, revised January 2026, included but was not limited to:*Medications shall be administered in a safe and timely manner, and as prescribed.-Medications must be administered in accordance with the orders, including any required time frame. -The following information must be checked/verified for each resident prior to administering medications.>Vital signs, if necessary. Review of the facility policy titled Vital Signs-Blood Pressure, revised 2/11, included but was not limited to:*A blood pressure (BP) is taken to determine the force of the blood flowing through the blood vessel and to obtain objective criteria to assess physical condition of residents.-Blood pressures are taken only by licensed staff.-Blood pressures are taken on admission, monthly, as ordered by physician, and when needed.-Blood pressures are taken weekly for resident receiving anti-hypertensive medications.-Document on vital sign flow sheet and write a clinical note for an abnormal blood pressure (low or high).-Report significant variance to Physician. 1.Resident #90 was admitted to the facility in July 2022 with diagnoses including Essential (Primary) Hypertension, Chronic Kidney Disease Stage 3A, Hypertensive Chronic Kidney Disease with Stage 1 through Stage 4 and sequelae of Cerebral Infarction. Review of Resident #90's May 2026 Physician's orders included:-Amlodipine Besylate Oral Tablet 2.5 milligrams (mg). Give 2.5 mg by mouth in the morning related to Essential (Primary) Hypertension. Hold if SBP is less than (<) 110, initiated 5/24/24. Review of the Resident #90's March 2026, April 2026 and May 2026, Medication Administration Record (MAR) indicated:-Amlodipine Besylate Oral Tablet 2.5 mg was administered to Resident #90 with no blood pressure assessment documented in the clinical record relative to the administration of the medication daily. During an interview on 5/7/26 at 12:07 P.M., the surveyor and Nurse #1 reviewed Resident #90's Physician's orders and MAR and Nurse #1 said the Physician's orders indicated to hold Amlodipine Besylate medication if the Resident's SBP was less than or equal to 110 mmHg. Nurse #1 said the check mark (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on Resident #90's MAR indicated that the Amlodipine Besylate had been administered to the Resident and the medication should not have been administered because there was no SBP assessment documented relative to administration of the medication. Nurse #1 said that the risk of not assessing the SBP prior to administering the Amlodipine Besylate to the Resident was undetected hypotension as the Resident's blood pressure had not been assessed relative to administering the medications. The surveyor and Nurse #1 reviewed the Resident's vital signs records and Nurse #1 said that the Resident's blood pressure was being assessed weekly and should have been assessed daily, prior to the medication being administered as ordered by the Physician. During an interview on 5/7/26 at 12:28 P.M., the surveyor, the Director of Nursing (DON) and Unit Manager (UM) #1 reviewed Resident #90's Physician's orders, MARs for March 2026, April 2026, and May 2026, and the Resident's vital signs records. UM #1 said that Resident #90's blood pressure should have been assessed prior to the administration of the Amlodipine Besylate. UM #1 also said that Resident #90's blood pressure should have been assessed and evaluated by nursing staff daily and not weekly. UM #1 further said that her expectation for nursing staff administering medication was to follow the Physician's orders. UM #1 said the risk of Resident #90 receiving Amlodipine Besylate when the Resident's blood pressure was not assessed was hypotension. 2. Resident #104 was admitted to the facility in February 2026 with diagnoses including Chronic Diastolic (Congestive) Heart Failure, Unspecified Atrial Fibrillation, Chronic Kidney Disease Stage 3B, Essential (Primary) Hypertension and presence of cardiac pacemaker. Review of Resident #104's active Physician's orders included:-Amlodipine Besylate Oral Tablet 2.5 MG. Give 2.5 mg by mouth in the morning related to ESSENTIAL (PRIMARY) HYPERTENSION. Hold for SBP less (<) or equal (=) to 105 or DBP less (<) or equal (=) to 60, initiated 2/18/26. -Torsemide Oral Tablet 20 MG. Give 1 tablet by mouth one time a day related to ACUTE ON CHRONIC DIASTOLIC (CONGESTIVE) HEART FAILURE. Hold for SBP < or = 105, and DBP < or = 60, initiated 2/19/26. -Valsartan Oral Tablet 160 MG. Give 1 tablet by mouth every 12 hours related to ESSENTIAL (PRIMARY) HYPERTENSION. Hold for SBP < 105 or DBP < 60, active 2/18/26 Review of Resident #104's February 2026 MAR indicated: >Torsemide Oral Tablet 20 mg was administered to Resident #104 outside of the Physician's ordered parameters as follows: -On 2/24/26 at 9:00 A.M.: DBP was documented as 54 mmHg. >Valsartan Oral Tablet 160 mg was administered to Resident #104 outside of the Physician's ordered parameters as follows:-On 2/19/26 at 9:00 P.M.: DBP was documented as 56 mmHg.-On 2/24/26 at 9:00 P.M.: DBP was documented as 58 mmHg. Review of Resident #104's March 2026 MAR indicated: >Amlodipine Besylate Oral Tablet 2.5 mg was administered to Resident #104 outside of the Physician's ordered parameters as follows:-On 3/1/26 at 9:00 A.M.: DBP was documented as 55 mmHg.-On 3/17/26 at 9:00 A.M.: DBP was documented as 58 mmHg.-On 3/31/26 at 9:00 A.M.: DBP was documented as 54 mmHg.>Torsemide Oral Tablet 20 mg was administered to Resident #104 outside of the Physician's ordered parameters as follows: -On 3/1/26 at 9:00 A.M.: DBP was documented as 55 mmHg.-On 3/17/26 at 9:00 A.M.: DBP was documented as 58 mmHg.-On 3/31/26 at 9:00 A.M.: DBP was documented as 54 mmHg.>Valsartan Oral Tablet 160 mg was administered to Resident #104 outside of the Physician's ordered parameters as follows:-On 3/1/26 at 9:00 A.M.: DBP was documented as 55 mmHg.-On 3/1/26 at 9:00 P.M.: DBP was documented as 52 mmHg.-On 3/3/26 at 9:00 P.M.: DBP was documented as 51 mmHg.-On 3/5/26 at 9:00 P.M.: DBP was documented as 56 mmHg.-On 3/13/26 at 9:00 P.M.: DBP was documented as 55 mmHg.-On 3/17/26 at 9:00 A.M.: DBP was documented as 58 mmHg.-On 3/31/26 at 9:00 A.M.: DBP was documented as 54 mmHg.-On 3/31/26 at 9:00 P.M.: DBP was documented as 51 mmHg. Review of Resident #104's May 2026 MAR indicated:>Amlodipine Besylate Oral Tablet 2.5 mg was administered to Resident #104 outside of the Physician's ordered parameters as follows:-On 5/3/26 at 9:00 A.M.: DBP was documented as 58 mmHg.>Torsemide Oral Tablet 20 mg was administered to Resident #104 outside of the Physician's ordered parameters as follows: -On 5/3/26 at 9:00 A.M.: DBP was documented as 58 mmHg.>Valsartan Oral Tablet 160 mg was administered to Resident #104 outside of the Physician's ordered parameters as follows:-On 5/3/26 at 9:00 A.M.: DBP was (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented as 58 mmHg. During an interview on 5/7/26 at 12:03 P.M., the surveyor and Nurse #1 reviewed Resident #104's Physician's orders and the February 2026, March 2026, and May 2026 MARs. Nurse #1 said the check mark on the MARs indicated the medications were administered to Resident #104. Nurse #1 said that the Physician's orders indicated to hold the anti-hypertensive medications if the SBP was less than or equal to 105 mmHg or DBP was less than or equal to 60 mmHg. Nurse #1 said the Amlodipine Besylate 2.5 mg, Torsemide 20 mg and Valsartan 160 mg should not have been administered to Resident #104 because the Resident's DBP was less than 60 mmHg on the dates listed. Nurse #1 said the Physician should have been notified if Resident #104's DBP was less than or equal to 60 mmHg and the medication had to be held. Nurse #1 said that the risk to Resident #104 was hypotension which could lead to dizziness. During an interview on 5/7/26 at 12:20 P.M., the surveyor, the Director of Nursing (DON) and UM #1 reviewed Resident #104's Physician's orders and MARs for February 2026, March 2026, and May 2026. UM #1 said that Resident #104's anti-hypertensive medications should have been held and not administered to the Resident. UM #1 said that the Physician should have been notified that the Resident's DBP was less than 60 mmHg. UM #1 said that the risk of the Resident receiving the anti-hypertensive medications when it should not have been administered was the risk of hypotensive complications. During an interview on 5/7/26 at 2:12 P.M., the Nurse Practitioner (NP) said if a resident had blood pressure parameters, her expectation was that nursing staff would assess and monitor the resident's vital signs including blood pressure monitoring as ordered. The NP said that she expected nursing staff to notify her if Resident #104's DBP was low. The NP said that it was important that nursing staff notify her so she could adjust Resident #104's medication to prevent complications.