| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355082 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/11/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **SMP HEALTH - AVE MARIA** | **501 19TH ST NE , JAMESTOWN, North Dakota, 58401** |

| (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) COMPLETION DATE |
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| F0000 | INITIAL COMMENTS<br><br>The standard Medicare/Medicaid recertification and complaint survey started on 12/08/25 and concluded 12/11/25. | F0000 | | 01/15/2026 |
| F0600<br>SS = D | Free from Abuse and Neglect<br><br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br><br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review, review of facility policy, and staff interviews, the facility failed to ensure 1 of 1 supplemental resident (Resident #35) was free from resident-to-resident abuse. Failure to assess, care plan, and follow the plan/process may result in physical harm, fear, anxiety, and psychosocial harm to all residents.<br><br>Findings include: Review of the facility policy titled, "Abuse" occurred on 12/11/25. This policy, dated January 2025, stated, "Each resident has the right to be free of verbal . . . abuse . . . To ensure these rights SMP [Sisters Mary of the Presentation] Health-Ave Maria has developed and implemented policies and procedures, which include the components of screening, training, prevention, identification, protection, investigation, and | F0600 | 1. Resident #4 was immediately moved to a different semi-private room as no private rooms were available. Resident #4 and new roommate were interviewed several times to ensure interactions were appropriate. Resident #4's family and provider were updated. Provider gave orders for a psychiatric provider referral. Resident #4's care plan was updated. Resident #4 was placed on behavior monitoring progress notes every shift for the next 14 days. Psychiatric provider assessed resident on 12/11/25 and dictated "undersigned does not feel there was any eminent threat of verbal or physical harm or ideation." As of 12/30/25 Resident #4 was moved into a private room.<br><br>Resident #35 was interviewed by several different management-level staff members, and all interviews found no feelings of intimidation, mental anguish, psychosocial harm, or any form of harm. Resident #35's provider was updated.<br><br>2. All residents have the potential to be affected.<br><br>3. On December 10, 2025, at 6:23 pm, all staff were provided education via the facility's mass texting system regarding the importance of notifying management immediately upon witnessing any form of potential abuse to include resident to resident abuse. On December 10, 2025, at 7:52 pm, an email was sent to all staff to educate on reporting any potential allegations of abuse. On December 10, 2025, at 7:59 pm, another message was sent via the facility's mass texting system to all staff with specific examples of abuse. On December 10, 2025, at 8:02 pm, all staff working in the facility were educated regarding the facility's abuse policy and the importance of notifying management immediately. On December 10th at 10:30 PM the night shift was educated. On December 11th, all staff | 01/15/2026 |

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 reverse for further 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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| F0600 SS = D | Continued from page 1<br>reporting/response. . . . Verbal abuse is defined as . . . intimidation . . . mental anguish . . ."<br><br>Review of the facility policy titled, "Behavior Management" occurred on 12/11/25. This policy, dated January 2025, stated, ". . . POLICY: Behavior monitoring and assessment will be carried out and documented. . . . PURPOSE: 1. To provide a baseline of behaviors and interventions. 2. To provide a means to set up a plan of care. 3. To provide a system of communicating, assessing, monitoring and implementing interventions for challenging behaviors of residents. . . . When a new behavior develops or an inappropriate behavior worsens, any Nurse or Social Service staff will document the occurrence. CNA's [sic] [certified nurse aides] can document in PCC [point click care] [electronic health record] . . . Inform physician of any significant behaviors . . .Initiate or revise care plan to focus/interventions with current information. . . . Ongoing assessments to evaluate occurrences for possible causes, patterns and/or trends along with appropriate interventions . . . A summary of behavior monitoring is documented in the Progress Notes by Social Services staff and review care plan for changes.<br><br>- Review of Resident #35's medical record occurred on 12/10/25 and identified an admission date of 10/10/25. On 10/22/25, Resident #4 moved into the same room as Resident #35.<br><br>During the initial tour of the facility on 12/08/25 at 1:15 p.m., Resident #35 identified no concerns, and stated, "everything is fine."<br><br>During the initial tour of the facility on 12/08/25 at 4:05 p.m., When asked Resident #4 about his roommate, the resident stated, "He's ok I guess. Just snores all the time."<br><br>- Review of Resident #4's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 11/14/25, showed a brief interview of mental status (BIMS) score of 9, indicating moderate cognitive impairment. The current care plan stated, ". . . is at risk for altered mood related to diagnoses of Anxiety Disorder . . . Depression . . . He takes prescribed psychotropic/Anti-anxiety medications . . . SW [social worker] will provide support as needed and review behaviors and/or mood concerns as documented by staff . . ." The care plan failed to include interventions for Resident #4's verbal behaviors toward his roommate, Resident #35.<br><br>Review of Resident #4's progress notes showed the | F0600 | Continued from page 1<br>working were educated on the abuse policy at the Code 1000 Abuse Education meeting. CNA staff were educated at the CNA meeting on 12/11/25. Nursing staff were educated at the Nurses' meeting on 12/18/25. All staff will be educated on resident care, dementia, and behaviors on 1/5/26 in addition to a review of the facility's abuse policy.<br><br>4. An audit tool has been developed, and a random audit began on 12/10/25 for all residents who display behaviors for twelve weeks, then monthly thereafter ongoing by our QA Nurse Manager, Nurse Manager, or designee to ensure that all potential abuse allegations are reported per the facility's abuse policy. The results will be discussed at the monthly QAPI meetings with action and follow-up completed as necessary.<br><br>5. Corrective action will be completed by January 15, 2026. | 01/15/2026 |

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| F0600 SS = D | Continued from page 2<br>following:<br><br>* 10/28/25 at 10:17 a.m. ". . . Time behavior occurred: 0700 [7:00 a.m.] . . . Resident witnessed by staff calling roommate: 'He's an asshole of a monkey' . . . CNA told resident that he isn't being very nice calling people names Resident response to intervention: [Resident #4] simply laughed and said 'well he is' . . ."<br><br>* 11/1/25 at 2:51 a.m. ". . . upset that roommate has tv on. tv volume down. reminded resident that roommate has right to have it on. calls roommate names. . . ."<br><br>* 11/24/25 at 10:24 p.m. ". . . calling room mate [sic] vulgar names and telling staff to 'knock him out' . . ."<br><br>* 12/5/25 at 4:03 a.m. ". . . Staff reported to the writer that the resident was saying to his roommate that if he knew how overweight he was, during a conversation with staff, [Resident #4] was informed that it was [not] appropriate to say things like that about other people. . . ."<br><br>* 12/5/25 at 9:27 p.m. ". . . staff reported as walking by room, heard resident yelling at roommate. When confronted resident asks staff 'to pull a blanket over [Resident #35's] head' reassured resident that he can't help it and resident replies 'yes he can when I yell at him he quits' . . ."<br><br>* 12/7/25 10:30 P.m. ". . . Observed Behavior: singing loudly when roommate starts snoring . . . multiple occurrences of yelling at roommate when roommate is snoring. . . ."<br><br>* 12/08/25 at 7:35 p.m. ". . . Time behavior occurred: afternoon on 12/6/2025 observed behavior: CNA wrote: Roommate 'was napping and [Resident #4's name] said to put a pillow over his face so he dies' . . ."<br><br>During an interview with Resident #35 on 12/10/25 at 4:35 p.m., when asked if he had any concerns with his roommate, Resident #35 stated, "I'm fine I don't know" and proceeded to put his head down on his chest and closed his eyes.<br><br>On 12/11/25 at 8:35 a.m., a surveyor attempted to have a conversation with Resident #35 regarding any concerns with his roommate the resident was sleeping.<br><br>During an interview on 12/10/25 at 5:25 p.m., when | F0600 | | 01/15/2026 |

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| F0600 SS = D | Continued from page 3<br>asked about Resident #4's behaviors with his roommate, a nurse (#8) stated, "You mean roommates? He has been having a hard time with every roommate. We tried several times to put him with other roommates, and he always finds something wrong with them." When asked if she was aware of Resident #4's comments to Resident #35 on 11/24/25 and 12/6/25, the nurse stated, "No I was not notified, and the administrator or social worker were also not notified." When asked what she expected staff to do following those behaviors, the nurse (#8) stated the nurse manager should have been called to ensure Resident #35's safety and when there's a threat like that because this is abuse.<br><br>During an interview on 12/11/25 at 9:50 a.m., an administrative staff member (#3), stated a CNA (#7) had informed her on Monday 12/08/25 at approximately 8:30 a.m. about Resident #4's behaviors towards his roommate that occurred on 12/06/25 and, "I told her she needed to fill out a behavior observation form. When I came to work Tuesday [12/09/25] morning the form was in the box outside of my office. The administrative staff member stated she informed the management team at the "stand up" meeting that morning.<br><br>A behavior observation form for Resident #4, dated 12/06/25 stated, ". . . [Resident #35] was napping and snoring. . . . [Resident #4] said to put a pillow over his face so he dies. Told him that was not nice and rude and he [Resident #4] said 'I don't care'. . ."<br><br>During an interview on 12/11/25 at 9:28 a.m., a nurse (#8) who worked on 12/06/25 stated, "I was not told about [Resident #4] behaviors and what he said to [Resident #35]. If I had known I would have called the on call unit manager."<br><br>An interview with a social services staff member (#6) occurred on 12/11/25 at 10:23 a.m., when asked if she was aware of Resident #4's behaviors with his roommate on 12/06/25, the staff member stated, "Just first heard about it yesterday when [staff member #2] told me."<br><br>The facility failed to:<br><br>* Identify Resident #4's behaviors as verbal abuse.<br><br>* Protect Resident #35 from abuse.<br><br>* Provide the services necessary to avoid verbal | F0600 | | 01/15/2026 |

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| F0600 SS = D | Continued from page 4<br>abuse.<br><br>* Utilize appropriate interventions when caring for residents exhibiting behaviors.<br><br>* Update Resident #4's care plan related to behaviors with past and current roommates.<br><br>* Assess and monitor Resident #4's behaviors for potential causes, patterns or trends, and develop a process/plan to alleviate the behaviors.<br><br>* Immediately report the abuse to administrative staff, physician, and state survey agency. | F0600 | | 01/15/2026 |
| F0609 SS = D | Reporting of Alleged Violations<br><br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review, review of facility policy, and staff interview, the facility failed to report incidents of resident-to-resident abuse to the State Survey Agency (SSA) for 1 of 1 supplemental resident | F0609 | 1. For Resident #4 a behavior care plan has been added. He is also now followed by a psychiatric Nurse Practitioner.<br><br>For Resident #35 he was interviewed by several different management-level staff members and no intimidation, mental anguish, psychosocial, or any other harm was identified. Provider was updated.<br><br>2. All residents have the potential to be affected.<br><br>3. On December 10, 2025, at 6:23 pm, all staff were provided education via the facility's mass texting system regarding the importance of notifying management immediately upon witnessing any form of potential abuse to include resident to resident abuse. On December 10, 2025, at 7:52 pm, an email was sent to all staff to educate on reporting any potential allegations of abuse. On December 10, 2025, at 7:59 pm, another message was sent via the facility's mass texting system to all staff with specific examples of abuse. On December 10, 2025, at 8:02 pm, all staff working in the facility were educated regarding the facility's abuse policy and the importance of notifying management immediately. On December 10th, at 8:20 pm, all members of the nurse leadership team were educated by the CEO/Administrator on the facility's abuse policy and procedures. On December 10th at 10:30 PM the night shift was educated. On December 11th, all staff working were educated on the abuse policy at the Code 1000 Abuse Education meeting. CNA staff were educated at the CNA meeting on 12/11/25. Nursing staff were educated at the Nurses' meeting on 12/18/25. All staff will be educated on resident care, dementia, and behaviors on 1/5/26 in addition to a review of the facility's abuse policy. | 01/15/2026 |

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| F0609 SS = D | Continued from page 5<br>(Resident #35) who experienced verbal abuse. Failure to report resident-to-resident abuse allegations places all residents at risk of potential abuse/neglect.<br><br>Findings include: Review of the facility policy titled, "Abuse" occurred on 12/11/25. This policy, dated January 2025, stated, "Each resident has the right to be free of verbal . . . abuse . . . Procedure . . .Any alleged incident must be reported to the North Dakota Health Department immediately (within 24 hours or less) . . ."<br><br>- Review of Resident #35's medical record occurred on 12/10/25 and identified an admission date of 10/10/25. Resident #4 was moved to the same room as Resident #35 on 10/22/25.<br><br>- Review of Resident #4's medical record occurred on all days of survey. The nursing progress notes showed the following:<br><br>* 11/24/25 at 10:24 p.m., stated, ". . . calling room mate [sic] vulgar names and telling staff to 'knock him out' . . ."<br><br>* 12/08/25 at 7:35 p.m., stated, ". . . Time behavior occurred: afternoon on 12/6/2025 observed behavior: CNA wrote: Roommate 'was napping and [Resident #4's name] said to put a pillow over his face so he dies' . . ."<br><br>The record lacked evidence the facility reported the above incident to the SSA as possible abuse.<br><br>During an interview on the morning of 12/10/25, an administrative staff member (#1) confirmed the facility did not report the above incidents to the SSA.<br><br>The facility failed to recognize name calling and threatening behaviors as abuse and report to the SSA. | F0609 | Continued from page 5<br><br>4. An audit tool has been developed and a random audit of 10 staff members through in-person interviews to ensure they are knowledgeable of the abuse policy and who and how to report to weekly that began on 12/10/25 for twelve weeks, then monthly thereafter ongoing by our QA Nurse Manager, Nurse Manager, or designee to ensure that all potential allegations are reported immediately to nursing. The results will be discussed at the monthly QAPI meetings with action and follow-up completed as necessary.<br><br>5. Corrective action will be completed by January 15, 2026. | 01/15/2026 |
| F0610 SS = D | Investigate/Prevent/Correct Alleged Violation<br><br>CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. | F0610 | 1. A thorough investigation has been completed by several members of the management team regarding the alleged violation with Resident #4. Resident #35 was interviewed by several different management-level staff members and no intimidation, mental anguish, psychosocial, or any other harm was identified.<br><br>2. All residents have the potential to be affected. | 01/15/2026 |

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| F0610 SS = D | Continued from page 6<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review, review of facility policy, and staff interviews, the facility failed to investigate an incident of resident to resident abuse for 1 or 1 supplemental resident (Resident #35) who experienced verbal abuse. Failure to investigate incidents of abuse may result physical harm, fear, anxiety, and psychosocial harm for all residents..<br><br>Findings include: Review of the facility policy titled, "Abuse" occurred on 12/11/25. This policy, dated January 2025, stated, "Each resident has the right to be free of verbal . . . abuse . . . To ensure these rights . . . policies and procedures, which include . . . investigation . . . All alleged abuse will be investigated by the Director of Nursing . . ."<br><br>- Review of Resident #35's medical record occurred on 12/10/25 and showed an admission date of 10/10/25 and Resident #4 was moved to the same room as Resident #35 on 10/22/25.<br><br>- Review of Resident #4's medical record occurred on all days of survey. Review of the progress notes showed the following:<br><br>* 11/24/25 at 10:24 p.m., stated, ". . . calling room mate [sic] vulgar names and telling staff to 'knock him out' . . ."<br><br>* 12/08/25 at 7:35 p.m., stated, ". . . Time behavior occurred: afternoon on 12/6/2025 observed behavior: CNA wrote: Roommate 'was napping and [Resident #4's name] said to put a pillow over his face so he dies' . . ."<br><br>A behavior observation form for Resident #4, dated 12/06/25 stated, ". . . [Resident #35] was napping and snoring. . . . [Resident #4] said to put a pillow over his face so he dies. Told him that was not nice and rude and he [Resident #4] said 'I don't care'. . | F0610 | Continued from page 6<br>3. On December 10, 2025, at 6:23 pm, all staff were provided education via the facility's mass texting system regarding the importance of notifying management immediately upon witnessing any form of potential abuse to include resident to resident abuse. On December 10, 2025, at 7:52 pm, an email was sent to all staff to educate on reporting any potential allegations of abuse. On December 10, 2025, at 7:59 pm, another message was sent via the facility's mass texting system to all staff with specific examples of abuse. On December 10, 2025, at 8:02 pm, all staff working in the facility were educated regarding the facility's abuse policy and the importance of notifying management immediately. On December 10th, at 8:20 pm, all members of the nurse leadership team were educated by the CEO/Administrator on the facility's abuse policy and procedures. On December 10th at 10:30 PM the night shift was educated. On December 11th, all staff working were educated on the abuse policy at the Code 1000 Abuse Education meeting. CNA staff were educated at the CNA meeting on 12/11/25. Nursing staff were educated at the Nurses' meeting on 12/18/25. All staff will be educated on resident care, dementia, and behaviors on 1/5/26 in addition to a review of the facility's abuse policy.<br><br>4. An audit tool has been developed to ensure that investigations are completed on any allegation of abuse to determine which actions are necessary (if any) for the protection of residents. QA Nurse Manager, Nurse Manager, or designee will complete audits upon any allegation of abuse. If concerns are identified, immediate corrective action will be implemented. The results will be discussed at the monthly QAPI meetings with action and follow-up completed as necessary.<br><br>5. Corrective action will be completed by January 15, 2026. | 01/15/2026 |

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| F0610 SS = D | Continued from page 7<br>."<br><br>During an interview on 12/11/25 at 9:50 a.m., an administrative staff member (#3), stated a CNA (#7) had informed her on Monday, 12/08/25, at approximately 8:30 a.m. about Resident #4's behaviors towards his roommate on 12/06/25 and, "I told her she needed to fill out a behavior observation form. When I came to work Tuesday morning [12/09/25] the form was in the box outside of my office." The administrative staff member (#3) stated she informed the management team at the "stand up" meeting of Resident #4's behaviors.<br><br>An interview occurred on 12/11/25 at 10:23 a.m., with a social service member (#6). When asked if she was aware of Resident #4's behaviors with his roommate that occurred on 12/06/25, she stated, “Just first heard about it yesterday when [staff member #2] told me.”<br><br>During an interview on 12/10/25 at 5:25 p.m., an administrative staff member (#1) stated neither her, the administrator or the social worker designee, were notified of Resident #4's behaviors therefore did not investigate any of his actions as abuse and did not report them to the SSA (State Survey Agency). | F0610 | | 01/15/2026 |
| F0684 SS = D | Quality of Care<br><br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br><br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and staff interview, the facility failed to ensure staff provided necessary care and services for 1 of 1 sampled resident (Resident #4) with diabetes. Failure to follow physician orders for out-of-range blood sugar levels may result in adverse health events.<br><br>Findings include: | F0684 | 1. For resident #4, on 12/10/25, the DON updated his medical provider, and she changed the orders for the parameters for his blood glucose monitoring. The new order is to notify provider with blood sugars above 400 or below 70, and symptomatic. The nurses have been educated to write a note in the medical record each time the provider is updated.<br><br>2. All residents who have blood glucose monitoring with specific parameters for updating providers are at risk for this practice.<br><br>3. Nursing staff were educated at the nurses' meeting on 12/18/25 regarding blood glucose monitoring specifically the need to update the medical record with the documentation of notification of the provider.<br><br>4. A QA tool has been developed and a random audit of 10 residents who have blood sugar parameters to ensure notification of provider is documented within the resident's medical record started on December 15, 2025, and will be completed | 02/21/2026 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355082 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/11/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SMP HEALTH - AVE MARIA** | **501 19TH ST NE , JAMESTOWN, North Dakota, 58401** |

| (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) COMPLETION DATE |
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| F0684 SS = D | Continued from page 8<br>Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 63, stated, ". . . It is the nurse's responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescriber. . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ."<br><br>Review of Resident #4's medical record occurred on all days of survey. Diagnoses included diabetes mellitus. The current care plan stated, " [Resident] has Diabetes mellitus with polyneuropathy [a degeneration of peripheral nerves]. . . . will be free from any s/sx [signs/symptoms] of hyperglycemia [high blood sugar] . . . will be free from any s/sx of hypoglycemia [low blood sugar] . . . will have no complications related to diabetes through the review date. . . . Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. . . ."<br><br>A physician's order, dated 09/28/25, stated, "Blood Glucose checks four times daily and as needed per nursing discretion. Notify MD [medical doctor] if Glucose is greater than 300 or less than 70."<br><br>Review of Resident #4's medication administration records from November 1, 2025 through December 9, 2025, showed 16 occasions blood glucose levels were greater than 300 milligrams per deciliter (mg/dL) (ranged from 301 mg/dL to 460 mg/dL) and 4 occasions blood glucose levels were less than 70 mg/dL (ranged from 58 mg/dL to 69 mg/dL). The medical record lacked documentation facility staff notified the provider of the out-of-range blood glucose readings.<br><br>During an interview on 12/11/25 at 12:21 p.m., an administrative nurse (#1) confirmed the medical record lacked documentation of provider notification.<br><br>The medical record failed to show nursing staff notified the provider to ensure proper care and services were provided regarding Resident #4's out-of-range blood glucose levels. | F0684 | Continued from page 8<br>for twelve weeks, then monthly thereafter by our QA Nurse Manager, Nurse Manager, and/or designee.<br><br>5. Corrective action will be completed by February 21, 2026. | 02/21/2026 |