STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105668	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Manor	777 South Douglas Road Pembroke Pines, FL 33025

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the resident's physician was notified regarding the resident's blood pressure medications that were held for three consecutive days due to low blood pressure for 1 of 3 sampled residents (Resident #2). The findings included:Review of the facility's Standard Practice policy titled Change in a Resident's Condition Status revised on 01/2025 documents it is the policy of (name of facility) to consult with the resident immediately and notify the Attending Physician of the following:..a significant change in the resident's physical, mental or psychosocial status; a need to alter treatment significantly or a decision to transfer or discharge the resident from the facility. The resident's legal representative or interested family member is to be notified of these changes as soon as possible. Resident/Family/Physician notification is to be documented in the Nurses' progress notes. Review of the facility's policy titled Administration procedures for all medication PH 180-113 revised on 01/2024 documents .notification of Physician/Prescriber: held medications for pulse, blood pressure.resulting in medications being held.Review of Resident #2's clinical record documented a readmission to the facility on [DATE] and a transfer to a local hospital on [DATE]. The resident's admitting diagnosis was Toxic Metabolic Encephalopathy and Hypertension. Review of Resident #2's care plan titled (Resident #2) is at risk for cardiovascular complications related to HTN (hypertension), hypokalemia and Anemia initiated on 07/25/25 with interventions to include: monitor vital signs to include BP (blood pressure) and Pulse. Notify physician of abnormal findings. Review of Resident #2's nurses notes dated 09/13/25 at 1:13 PM, documented a heart rate (HR) of 84, a blood pressure (BP) of 90/55. The nurse note lacked written evidence that the resident's physician was notified of a change of the resident's low BP. Review of Resident #2's nurses note written by Staff B, Registered Nurse (RN) dated 09/14/25 at 9:00 AM documented a HR of 114, a BP of !84/50 (the BP reading was documented in red and had a question mark next to the reading), BP low again this AM, resident denies dizziness, fatigue or blurred vision, but HR of 114. Resident has no appetite for current meal. The clinical record lacks written evidence that the physician was notified of a change of the resident's low BP and elevated HR. Review of Resident #2's nurse note dated 09/15/25 at 8:20 AM documented a HR of 111, a BP of !76/52 (question mark next to the reading noted). Appears weak with poor appetite despite encouragement. PA (Physician Assistant) evaluated. Pending new orders.Review of Resident #2's September 2025's MAR documented that the resident's blood pressure medications:- Irbesartan (Avapro) 150 milligrams (mg) daily at 9:00 AM that was started on 08/04/25, was not given on 09/12/25, 09/13/25 and 09/14/25. -Metoprolol (Toprol XL) 24-hour tablet 50 mg daily at 9:00 AM that was started on 08/02/25, was not given on 09/12/25, 09/13/25 and 09/14/25. - Nifedipine (Adalat) 24-hour tablet 60 mg daily at 9:00 AM that was started on 08/02/25, was not given on 09/12/25, 09/13/25 and 09/14/25. Further review revealed no written evidence of Resident #2's physician notification regarding low BP, elevated HR and not given/held the resident's blood pressure medications on 09/12/25, 09/13/25 and 09/14/25. On 10/27/25 at 11:52 AM, an interview was conducted with Staff A, Registered Nurse (RN), who was asked what do you consider a resident change in condition and stated a mental status change, appetite not as usual and vital signs off from normal. Staff A was asked what would you do then and replied she will call the doctor.On 10/27/25 at 2:10 PM, an interview and a side-by-side review of Resident #2's clinical record was conducted with the Director of Nursing (DON). The review revealed the resident had a low BP on 09/13/25, and on 09/14/25. The DON was apprised the resident's BP readings were off from her baseline, prior documented readings were anywhere from 130's 150's and 160's with HR readings between 70's and 80's and had an elevated HR 144 on 09/14/25. The DON was asked to submit written evidence regarding Resident #2's physician notification of low BP, an elevated HR and not given BP medications for three (3) consecutives days. The DON stated she did not see any written notification to the physician. On 10/27/25 at 3:12 PM, an interview was conducted with Staff B, RN who was asked what would you do if your resident has a change in vital signs and replied, call the supervisor, call the doctors, get new orders, send them out and call the family. Consequently, a side-by-side review of Staff B's nurses note dated 09/14/25 for Resident #2 was conducted. Staff B was asked if she notified Resident #2's low blood pressure reading of 84/50 and the heart rate of 114 to the physician and stated she rechecked the blood pressure one hour later and it was okay. The RN was asked why she did not notify the physician of the changes to the BP and HR and stated she looked at the history and noticed the blood pressure reading was kind of baseline, was asymptomatic, added the resident was not