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	10/14/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews, and record review, the facility failed to monitor the behaviors of residents who are receiving psychotropic medications for 4 of 5 sampled residents reviewed for unnecessary medication (Resident #94, Resident #79, Resident #73, and Resident #1). The findings included: A review of the facility ' s policy titled Use of Psychotropic Medication revised in October 2022 revealed the following: Resident are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnoses and documented in the clinical record, and medication is beneficial to the resident, as demonstrated by monitoring and documentations of the resident ' s response to the medications. 1) Record review revealed that Resident #94 was admitted to the facility on [DATE] with diagnoses of Mild Dementia, Major Depressive Disorder, and Type 2 Diabetes. The Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #94 has a Brief Interview of Mental Status (BIMS) score of 11, indicating moderately cognitively impaired. A review of a Physician 's order revealed an order for Zoloft (antidepressive medication) 25 milligrams daily, which was dated 09/03/24. In an interview conducted on 10/11/24 at 1:00 PM with Resident #94, it was revealed that she did not remember seeing a psychologist for her anxiety and depression. She is currently not having any symptoms of anxiety and anxiousness. Review of the care plan, which started on 09/10/24, revealed the following: Resident #94 had psychosocial anxiety with the goal of not having the anxiety interfere with daily life functions. Interventions are in place to administer appropriate medications as ordered and monitor for effectiveness of medications-a care plan for psychosocial behaviors with interventions to monitor for changes/severity of behavioral symptoms. Further review revealed a care plan, which started on 09/10/24, for psychosocial-mood documented, with interventions in place: Monitor mood state and report changes to appropriate disciplines. Administer medications as ordered. (continued on next page)

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Monitor the effectiveness of medications. A review of the Behavior Monitoring Flow Sheet did not show that any behavior monitoring was done for Resident #94 since admission on 09/03/24. Record review revealed that Resident #94 was seen by a psychologist on 10/9/24 for situational depression and major depressive disorder. A review of the progress notes completed by nursing did not show any documentations regarding behavior monitoring. In an interview conducted on 10/11/24 at 1:05 PM with Staff C, a Registered Nurse (RN) she stated that any behaviors observed of the residents are documented in the progress notes for every medication that was administered to them. This included behavioral examination and observation of the patient for any signs of agitation, anxiety, and extreme depression that she defined as being quiet and sleepy. She further reported that if no behaviors are observed she documents as stable. In this interview, Staff C did not mention any Behavior Monitoring Flow Sheet. In an interview conducted on 10/11/24 at 1:15 PM with Staff A, RN, she stated that residents on psychotropic medications are being monitored for behaviors and documented on a specific behavior flow sheet that she created herself. Nursing supervisors fill out that particular behavior flow sheet, but the bedside nurse observes. In an interview conducted on 10/11/24 at 1:20 PM with the facility's Director of Nursing, the director stated that the behavior flow sheet is completed only when a resident has a present behavior. When behaviors are present, they are documented in the progress notes (narrative) and noted as stable. In an interview conducted on 10/11/24 at 1:23 PM with Staff A, she acknowledged that Resident #94 did not have a completed behavioral flow sheet since admission on 09/03/24. 41837 2) Record review for Resident #79 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Paraplegia, Intracranial Injury with Loss of Consciousness, and Sequela. Review of the Minimum Data Set for Resident #79 dated 10/03/24 documented in Section C a Brief Interview of Mental Status score of 15 indicating a cognitive response. Review of the Nurse Progress Notes for Resident #79 from 09/01/24 to 10/14/24 revealed no documentation of behaviors being monitored. Review of the Behavior Monitoring Flow Sheet for Resident #79 from 09/01/24 to 10/14/24 revealed no Behavior Monitoring Flow Sheet. Review of the Physician's Orders for Resident #79 revealed an order dated 06/27/24 for Mirtazapine (Remeron) 15 mg oral at bedtime for Major Depressive Disorder. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan for Resident #79 dated 10/04/24 with a problem of resident is at risk for adverse side effects related to use of psychotropic medication Diagnoses Anxiety and Depression. The goal was for the resident to have no injury to medication usage/side effects through next review date. The interventions included monitor for confusion and sedation, Monitor moods and behavioral patterns. Notify MD of any significant changes. Gradual dose reduction as needed. During an interview conducted on 10/14/24 at 9:25 AM with the Director of Nursing who stated she has worked at the facility for 6 years. When asked about behavior monitoring for residents on psychotropic medications, she stated If resident is receiving a psychotropic medication, the resident would be monitored for behaviors, and this would be documented on the behavior monitoring flow sheet or it could be documented in the nursing progress notes. They only document if the resident is having behaviors, they do not document if the resident has no behaviors. They chart by exception. When asked about monitoring behaviors for Resident #79 the DON acknowledged there was no Behavior Monitoring Flow Sheet for the resident. The DON also acknowledged there were no Nursing Progress Notes for the resident that document with information specifically pertaining to behaviors. When asked if they have any facility policy indicating they document by exception, she said no. During an interview conducted on 10/14/24 10:44 AM with Staff D Consultant Pharmacist, since May 2024. When asked when a resident is on psychotropic medication, does he check if the resident is being monitored for behaviors, he stated yes, he does, he believes they chart by exception. If they have no Behavior Monitoring Flow Sheet, he would assume the resident is not having any behaviors. When asked about an example of a Behavior Monitoring Flow Sheet for Resident #79 which documented an outcome code as same, and then improved and was asked what this indicates, he said I would not know. It was noted that this improved behavior documentation did not specify which behavior this resident experienced and what had improved. During an interview conducted on 10/14/24 at 11:22 AM with Staff E, Registered Nurse who stated she has worked at the facility for 2.5 years. Staff E was asked if a resident is receiving a psychotropic medication does she document for behaviors. She stated yes, if resident is screaming or fighting with staff, she would document this on the note (Nursing Progress Note) for the day. When asked about documenting on a behavior monitoring flow sheet, she said no she does not use this. 49060 3) Record review for Resident #73 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Coronary Artery Disease; Diabetes Mellitus, type II; Venous Insufficiency; Vertigo. Review of Section C of the Minimum Data Set (MDS) dated [DATE] revealed that Resident #73 had a Brief Interview for Mental Status (BIMS) of 13, which indicated that he was cognitively intact. Review of Section N revealed that Resident #73 was on an antidepressant. Review of the Physician's Orders showed that Resident #73 had an order dated 08/22/24 for Cymbalta (Duloxetine) capsule 20mg for Depression. Review of the Physician's Orders showed that Resident #73 had an order dated 09/09/24 for Remeron (Mirtazapine) tablet 7.5mg for Appetite loss. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Orders for Resident #73 did not include orders for side effects monitoring and no orders for behavior monitoring for psychotropic medications. Review of the Care Plan dated 08/27/24 documented that Resident #73 is at risk for adverse side effects related to (r/t) use of psychotropic medication due to diagnosis: Depression and Adjustment Disorder with Anxiety. The goal for the resident was to have no injury related to the medication usage and/or side effects through the review date. The interventions included: Administer medication as ordered; Report any negative observation to MD; Monitor for confusion and sedation; Monitor moods and behavioral patterns; Gradual dose reduction as needed. Review of the Nursing Note/assessment dated from 08/22/24 to 10/08/24 revealed no documentation of side effects or behavior being monitored for Resident #73. An interview conducted on 10/11/24 at 10:15 AM with DON. She stated residents on psychotropic medications are monitored for behaviors only if the behavior is observed, and then documented by the nursing management under the Behavior Monitoring Flow Sheet (BMFS) in the computer system. She also stated if the resident has not shown any behavior changes, there will not be a BMFS in the resident's chart. 50895 4) A record review on 10/14/24 09:19 AM revealed that Resident#1 was admitted to the facility on [DATE] with diagnoses that included Agitation, Anxiety, Depressive disorder, Mental disorder, Dysphagia, GERD, Intracerebral hemorrhage, Psychosis, Seizures, and Unspecified cerebral artery occlusion with cerebral infarction. The Brief Interview for Mental Status (BIMS) score was 0 on the Minimum Data Set (MDS) assessment Quarterly assessment dated [DATE]; this indicated that Resident #1 had severe cognitive impairment. This MDS assessment also showed that Resident #1 was administered antipsychotics on a routine basis for anxiety and depression. According to Resident #1's Physician's orders, she was on Diazepam since 09/17/24 (5 mg twice a day for anxiety), Mirtazapine since 02/06/24 (30 mg at bedtime for depressive disorder), and Quetiapine since 02/06/24 (50 mg every 8 hours for Depression). These are psychotropic medications. Resident #1's care plan dated 08/08/24 stated that Resident #1 was at risk for adverse side effects related to use of psychotropics. The interventions for that problem included to monitor for confusion and sedation, and to monitor for moods and behavioral patterns. The MD (Medical Doctor) was to be notified of any significant changes. In addition, the care plan stated that Resident #1 has a history of periods of agitation and resistance of care at times. The specified goal was that the resident's mood state would not interfere with daily life functioning. The interventions included to monitor mood state and to report changes to appropriate disciplines. Another care plan for Resident #1 stated that the resident had the potential for symptoms of mood disorders; the interventions included to monitor mood state and to report the changes to the appropriate disciplines. A review of the Behavior Monitoring for Psychotropic Meds report beginning 09/01/24 and ending 10/13/24 showed no documentation of behavior monitoring on 09/03/24, 09/10/24, 09/11/24, 09/16/24, 09/18/24, 09/24/24, 09/25/24, 09/27/24, 09/28/24, 09/29/24, 09/30/24, 10/05/24, 10/06/24, 10/08/24, 10/09/24, and 10/11/24. Photographic evidence obtained.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews and chart review, the facility, failed to provide the correct diet consistency, for the Pureed diet observed during 2 of 2 observations for Resident #34. This had the potential to effect 10 residents on a Pureed diet. The findings included: A review of the International Dysphagia Standardization Initiate (IDDSI) Descriptions provided by the facility's Speech Therapy Pathologist revealed the following: Pureed diet level 4: falls off the spoon when tilted. It continues to hold its shape in a plate. It cannot be drunk from a cup or sucked from a straw. It can be molded and does not require chewing. It has no lumps or stickiness. A chart review showed that Resident #34 was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease, Bipolar Disorder, and Depression. The Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score indicating Resident #34 is rarely understood. In an observation conducted on 10/07/24 at 12:43 PM, Resident #34 was observed eating her lunch meal in her room. The meal ticket was noted to have the following: pureed chicken, mashed potatoes, pureed broccoli, pureed bread, and pureed cobbler. The meal plated was noted with pureed chicken, mashed potatoes, pureed broccoli, pureed cobbler, and pureed bread, noted with lumpy pieces and not having one uniform consistency (photographic evidence obtained). In an observation conducted on 10/08/24 at 8:43 AM, Resident #34 was eating her breakfast tray in the room. The breakfast tray consisted of pureed fortified oatmeal, pureed cheese omelet, pureed ham, and pureed bread, which was noted to have lumps and not one uniform consistency (photographic evidence obtained). In an interview conducted on 10/14/24 at 8:25 AM with Staff B, the Speech-Language Pathologist, it was stated that the pureed diet should be smooth and creamy with no solid particles. It should not have any lumps or pieces. According to Staff B, most of the pureed foods are bought by an outside company, and only certain food items are prepared in-house. In an interview conducted on 10/14/24 at 9:10 AM, the Food Service Director stated that Pureed bread is not bought from an outside company and is made in-house. She further said that 10 residents are on a pureed diet. When photographic evidence of the pureed diet was shown, she acknowledged that it was not within the guidelines of a pureed diet consistency.