STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215073	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lions Rehab Center	901 Seton Drive Cumberland, MD 21502

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview it was determined that the facility failed to notify resident's physician when medications were held. This was evident for 1 (R#62) of 3 residents reviewed for notification of medications not given during the complaint survey. The findings include: On 5/27/25 at 1:45 PM a record review of Resident #62's Medication Administration Record (MAR) for May 2025 revealed an order for metoprolol (a medication that lowers blood pressure) with the instruction to hold for a systolic blood pressure (SBP) [top number of blood pressure] of 110 or less, or for a heart rate (HR) of less than 60 beats per minute. The MAR entries on 5/03/25, 5/04/25, 5/15/25, 5/16/25, 5/21/25 indicated that the medication was held on those days due to either low SBP or low HR. Further review failed to reveal any documentation that the resident's physician was notified that the medication was held on those days. On 5/27/25 at 1:56 PM an interview was conducted with the Director of Nursing (DON) to review Resident #62's MAR for May 2025. She confirmed the finding that the resident's metoprolol was held on 5/03/25, 5/04/25, 5/15/25, 5/16/25, 5/21/25. She then reviewed the nursing documentation and confirmed that there was no documentation of any physician notification for the doses not given. The Regional Nurse (Staff #6) later also affirmed the deficiency after she searched for but could not find evidence of physician notification.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview it was determined that the facility failed to complete thorough investigations of allegations of abuse. This was evident for 1 (#MD00217463) of 7 facility reported incidents reviewed during the complaint survey. The findings include: On 5/29/25 at 9:45 AM a review of the facility reported incident #MD00217463 revealed an allegation that staff verbally abused Resident #516 on 4/30/25. A review of the facility's investigation file revealed several typed resident interview statements. All of the resident statements lacked the name of the interviewer and the date the interview was conducted. The investigation file also contained staff interview statements from 2 Geriatric Nursing Assistants (GNA #16 & GNA #17). GNA #16's statement indicated that she was not assigned to the resident at that time, and GNA #17's statement did not indicate if she worked with the resident at that time. The file also lacked a list of staff who worked on the resident's unit that day, and lacked any evidence that abuse education was provided to staff after the incident. On 5/29/25 at 10:01 AM an interview was conducted with the Director of Nursing (DON) to review the facility's investigation. She confirmed the finding that the facility's investigation was not thorough.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and interviews it was determined that the facility failed to maintain medical records in accordance with professional standards. This was evident for 1 (MD00215206) of 7 facility reported incidents investigated during the complaint survey. The findings include: A review of the facility reported incident (FRI) #MD00215206 revealed that Resident #509 had an unwitnessed fall on 2/26/25. On 2/27/25 a nursing assessment revealed that the resident's left wrist was swollen and discolored. An x-ray was ordered and done on 2/27/25 and showed that the resident's left wrist was fractured. A review of the facility's investigation file was conducted on 5/28/25 at 9:20 AM. The file contained two duplicate handwritten documents, dated 3/06/25, signed by the consultant orthopedic Physician Assistant (Staff #15). One form contained notations of a capital letter R within a circle to indicate that the resident's right wrist was affected. The other document contained notations of a capital letter L within a circle, to indicate that it was the resident's left wrist that was affected. The documents were otherwise identical. An interview was conducted with the Director of Nursing (DON) on 5/28/25 at 10:05 AM to review the documents. The DON said that she knew the original form incorrectly indicated that Resident #509's right wrist was fractured, and she said she notified Staff #15 to ask for corrected documentation. When the DON was asked who altered the documentation to indicate the left wrist was affected, she said she was not sure but thought that Staff #15 did so. On 5/28/25 at 11:38 AM a telephone interview was conducted with Staff #15. When asked how he would make a correction to a medical record he said that sometimes his staff would write a separate notation to amend the record or that he would write an addendum but that he did not do so in this case. He also said that he did not change Resident #509's document to write L in place of R. On 5/28/25 at 12:34 PM in another interview with the DON, she pointed out that the form that had the L on it had a fax number at the top which indicated that it was sent to the facility from Staff #15's office. She said she did not know who altered the form, but she confirmed that the facility did accept the document and placed it in Resident #509's record. She stated that the document was incorrectly amended, and she confirmed the deficiency.

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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. Based on record review and interviews, it was determined that the facility failed to ensure that residents received ordered medications or treatments. This was evident for three (Resident #36, #12, and #3) out of 29 residents reviewed for medical records. The findings include: On 5/28/2025 at approximately 11:00 a.m., the surveyor reviewed the Medication Administration Records (MAR) and Treatment Administration Records (TAR) for Residents #36, #12, and #3. The surveyor found that the following physician-ordered medications and treatments were missed: Resident #36 On 5/4/25 (6:00 a.m. dose) - Acetaminophen, oral tablet 1000 mg, three times a day for chronic pain, was not administered. On 5/3/25 (5:00 p.m. dose) and 5/4/25 (6:00 a.m. dose) - Blood sugar checks with Humalog injection solution (100 units/mL, sliding scale), subcutaneously four times a day for diabetes management, were missed. On 5/16/25, 5/17/25, and 5/18/25 - All scheduled doses (6:00 a.m., 11:00 a.m., 4:30 p.m., and 10:00 p.m.) of blood sugar checks with Insulin Aspart FlexPen injector (100 units/mL, sliding scale), subcutaneously before meals and at bedtime for diabetes management, were not administered. Resident #12 On 5/4/25 (6:00 a.m.) - Levothyroxine Sodium, 150 mcg tablet, once daily for low thyroid hormone, was not administered. On 5/4/25 (6:00 a.m.) - Blood sugar check and Insulin Aspart FlexPen (100 units/mL, sliding scale), subcutaneously every morning and at bedtime for diabetes management, were missed. On 5/4/25 (6:00 a.m.) - Megestrol Acetate, oral tablet 40 mg, one tablet three times daily for benign endometrial hyperplasia, was not administered. Resident #3 On 5/1/25 (night shift) - The physician's order to maintain the port in the right chest and monitor for signs and symptoms of infection every shift was not followed. On 5/28/25 at 1:20 p.m., the surveyor spoke with the facility's Director of Nursing (DON) regarding concerns that, based on a review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR), several residents had missed medications and treatments. The surveyor requested that the DON review the records for Residents #36, #12, and #3. Specifically: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #36 had missed administration of Acetaminophen on 5/4, Humalog on 5/3 and 5/4, and Insulin on 5/16, 5/17, 5/18, and the morning of 5/19. Physician orders indicated that blood sugar checks were required prior to administering Humalog and Insulin. Resident #12 missed doses of Levothyroxine, Insulin, and Megestrol, all on 5/4. Resident #3 had a missed order on 5/1 to maintain the port in the right chest and monitor for signs and symptoms of infection every shift. The DON stated she would investigate and determine whether any documentation existed to confirm that the medications and treatments had been provided. Approximately 30 minutes later, the DON informed the surveyor that the residents had not received the medications and treatments. On 5/29/25 at 8:15 a.m., the surveyor spoke with the Regional Director (Staff #7) and the Consultant Registered Nurse (Staff #6). They were informed of the findings that Residents #36, #12, and #3 did not receive the medications or treatments as previously discussed with the Director of Nursing (DON). Both staff members acknowledged that the DON had already informed them of the issue.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, record reviews and interviews, it was determined that the facility failed to ensure that a resident's urine collection bag was secured off the floor. This was evident in 1 (Resident #502) of 3 residents reviewed for urinary catheters. The findings include: Resident #502 had been residing in the facility since early 2025. Medical records indicated that the resident was admitted with a foley catheter. A Foley catheter is a device that drains urine (pee) from your urinary bladder into a collection bag outside of your body when you can't pee on your own or for various medical reasons. Securing a urine collection bag is crucial to prevent leaks, reduce the risk of infection, and ensure proper catheter function, as well as prevent damage to the bladder neck or urethra. On 5/27/25 at 9:47 AM, Resident #502 was observed in bed sleeping with the urine collection bag laying on the floor. The Geriatric Nursing Assistant (GNA #8) who was assigned to the resident's unit confirmed the resident's name by pointing the resident out to the surveyor then left the area. Later at 10:05 AM, GNA #8 was observed entering Resident #502's room and confirmed that his/her urine collection bag was laying on the floor. GNA #8 reported that she was getting ready to clean the resident up. A review of Resident #502's care plan for catheter care was conducted on 5/27/25 at 2:49 PM. The review revealed interventions that read Maintain 16 fr 10 ml catheter tubing and bag above the floor and below the level of the bladder. Maintain tubing without kinks or occlusions. Secure catheter with leg strap if needed. Use universal precaution when handling urinary drainage. The Director of Nursing (DON) was interviewed on 5/29/25 at 9:19 AM. During the interview, the concern was discussed with the DON that the facility staff failed to secure Resident #502's urine collection bag off the floor. The DON acknowledged the concern and reported that she would be educating staff of the concern.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on medical review and staff interview, it was determined that the facility failed to document the reasons for administering as-needed (PRN) pain medications, failed to document the pain assessment to include intensity of pain, location of pain, and description of pain, and failed to implement non-pharmacological interventions before administering pain medication to residents. This was evident for 2 (#24 and #64) of 3 residents reviewed for pain management. The findings include: A pain intensity scale is one way to measure pain. The pain scale helps track how well a treatment plan is working to manage pain. Most pain scales use numbers from 0 to 10. A score of 0 means no pain, and 10 means the worst pain one has ever known. On 5/27/25 at 10:30 AM a record review of the Pain Control Policy revealed that assessing a resident's pain should include the frequency, duration, intensity of the pain when a resident gets regularly scheduled and/or PRN analgesics. The physcisian should order Non-pharmacological Interventions (NPI). On 5/28/25 at 11:06 AM a record review of Resident #24's physician orders revealed Acetaminophen Oral Tablet Give 650 mg by mouth every 6 hours as needed for mild to moderate pain, evaluate and address pain as needed and document NPI. On 5/28/25 at 11:29 AM a record review for Residents #24's Medication Administration Record (MAR) dated March 2025 revealed Acetaminophen 325 mg tablet 2 tablets was administered for pain on 3/2, 3/11, 3/14, and 3/16. The associated pain intensity scale indicated 5, 4, 5 and 5 respectively. However, there was no documentation of pain location and description nor NPI. On 5/28/25 at 11:39 AM a record review of Resident #64's orders revealed oxycodone HCl Oral Tablet 10 MG. Give 10 mg by mouth four times a day for Chronic Pain rated >6/10. Acetaminophen Oral Tablet 325 MG. Give 650 mg by mouth every 4 hours as needed for pain below 5. On 5/29/25 at 7:49 AM a record review of Resident #64's MAR dated March 2025 revealed Oxycodone HCL oral Tablet 10 mg was signed off as given every four hours with an associated pain intensity scale but without pain location and/or description. It also revealed Resident #64 received acetaminophen every eight hours without any associated pain assessment. On 5/29/25 at 8:55 AM in an interview, the Director of Nursing (DON) confirmed that managing a resident's pain included an assessment at least every shift and when giving PRN medications. A pain assessment includes location, intensity, description and in/effectiveness. She confirmed NPI is part of pain management. She reviewed Residents #24 and #64's MAR and acknowledged the concerns.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on record review and staff interview, it was determined that the facility failed to ensure a resident received their medications according to the attending physician's orders. This was evident for 1 (#518) out of 3 residents reviewed for medication regimen review (MRR). The findings include: A medical record review on 5/29/2025 at 10:43 AM showed that an MRR was completed by a pharmacist for Resident #518 on 3/21/25 with a recommendation to the resident's attending provider. The recommendation indicated that Resident #518 had been taking an antiulcer drug 40mg every day since 2023. It recommended a dose reduction to 20mg. A continued review revealed that Resident #518's attending provider responded to the recommendation on 3/28/25 with a new order to reduce the medication to 20mg daily. Further review of Resident #518's Medication Administration Record (MAR) from March 28 to May 30, 2025, revealed that the resident continued to receive the antiulcer medication at a total daily dosage of 60 mg, consisting of the 40 mg daily, and a newer dosage of 20 mg daily. In an interview on 5/29/2025 at 11:43 AM, the director of nursing (DON) checked Resident #518's MAR with the surveyor and confirmed that the resident continued to receive the antiulcer drug at 40mg every day together with a newer dose of 20mg daily after the attending provider gave the order to decrease it to 20mg daily. In a subsequent interview, the DON said the staff should have discontinued the antiulcer drug at 40 mg daily and only given the 20mg daily. The DON indicated that it was a medication error.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record review, observation, and staff interview, it was determined that the facility failed to implement Enhanced Barrier Precautions (EBP) as part of the infection prevention and control program. This was evident for 2 (Resident #40 and Resident #503) of 3 residents reviewed for pressure ulcers. The findings include: Enhanced Barrier Precautions (EBP) are defined by the Centers for Disease Control and Prevention (CDC) as a targeted infection prevention intervention requiring gown and glove use for high-contact care activities in residents with wounds, indwelling medical devices, or colonization/infection with multidrug-resistant organisms (MDROs). High-contact care activities involve extensive, close physical contact between staff and the residents and are more likely to result in the transmission of infectious agents. These include but are not limited to dressing the resident, bathing/showering, transferring the resident, providing hygiene (e.g., assist with toileting, oral care), changing linens, providing wound care, providing device care or use (e.g., care of feeding tubes, urinary catheters, IV lines). 1) Resident #503 had orders for daily wound care, a history of pressure ulcers as well as a recent infection involving a pressure ulcer. On 05/28/2025 at 1:53 PM, during a wound care observation for Resident #503 performed by Nurse #18 and Staff #3, the facility failed to implement EBP. The Resident had an active wound requiring dressing changes, and during the observation neither Nurse #18 or Staff #3 adhered to enhanced Personal Protective Equipment (PPE) requirements by failing to wear a protective gown in addition to the gloves they each were already wearing. Further review of the medical record on 5/28/25 failed to reveal a physician order for EBP, nor was there any documentation or care plan indication that EBP was being used or considered. 2) On 05/28/25 at 2:23 PM, a review of Resident #40's record revealed the need for wound care. However, the record did not document EBP implementation or assessment, and resident #40's doorway area was observed on 05/28/25 at 3:00 PM, and there was no signage indicating the need for EBP. On 05/28/2025 at 2:45 PM, the DON confirmed that EBP should be implemented for residents with pressure ulcers. The DON was made aware of concerns regarding the dressing change observed earlier that afternoon for Resident #503, when staff failed to wear gowns as required. The DON was also made aware of concerns related to no physician order for EBP for either Resident #503 or #40.