

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215073	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2025
NAME OF PROVIDER OR SUPPLIER Lions Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 901 Seton Drive Cumberland, MD 21502	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on record reviews and interviews, it was determined that the facility failed to ensure accurate dispensing and administration of medications. This was evident for 1 (Resident #5) of 1 resident reviewed for pain management. The findings include: On 10/27/25 at 10:32 AM, a review of the allegations related to complaint #2598971 indicated that Resident #5 was not getting the pain medication ordered for comfort care. A review of Resident #5's progress notes was conducted on 10/27/25 at 10:45 AM. A progress note with an effective date of 8/14/25 at 10:37 AM, indicated a verbal order from the physician to administer 5 ml of Morphine every 3 hours for pain and to discontinue all other medications. On 10/28/25 at 9:28 AM a review of Resident #5's narcotic count sheet was conducted with the Director of Nursing (DON). The review revealed that the morphine solution 10mg/5ml was delivered on 8/15/25. Further review of the narcotic count sheet revealed that the nursing staff had initially used the morphine solution with a stock dose of 10mg/5ml and pulled 0.25ml for each administration from 8/15/25 through 8/24/25, for a total of 22 times by different nurses. The 22 doses documented on Resident #5's narcotic count sheet were compared to the electronic medication administration record (eMAR) on 10/28/25 at 9:59 AM. There were no documentations to indicate that the medication was administered 5 out of the 22 times it was pulled from the stock solution. All 5 entries (on 8/15/25 at 2PM; 8/17/25 at 2:30PM; and 8/22/25 at 8:30AM, 2:20PM, and 8PM) in the narcotic count sheet were documented by a licensed practical nurse (LPN #5). The findings were discussed with the Director of Nursing (DON) on 10/28/25 at 10:20 AM. The DON indicated that she would review Resident #65's medical records. In a subsequent interview with the DON on 10/29/25 at 11:32 AM, she confirmed that LPN #5 had no documentation to indicate that she had administered the medication on the dates stated above. She also reported that LPN #5 was an agency nurse and had reached out to the agency for clarification but had not gotten a response. Until then, LPN #5 was placed on a list of agency staff that were not allowed to come back to work in the facility. On 10/29/25 at 1:03 PM, the concern was discussed with the DON that the facility had failed to ensure accurate dispensing and administration of medications. The DON verbalized understanding and acknowledged the concern.</p>

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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on record reviews and interviews, it was determined that the facility failed to ensure residents are free from significant medication errors. This was evident for 1 (Resident #5) of 1 resident reviewed for pain management. The findings include: On 10/27/25 at 10:32 AM, a review of the allegations related to complaint #2598971 indicated that Resident #5 was in comfort care. However, the pain medication used was ineffective and the resident was complaining of pain and discomfort. A review of Resident #5's progress notes was conducted on 10/27/25 at 10:45 AM. A progress note with an effective date of 8/14/25 at 10:37 AM indicated that the resident was to receive 5 ml of Morphine every 3 hours for pain from a verbal order from the physician. The next progress note with an effective date of 8/14/25 at 10:54 AM indicated that the order for Morphine was checked and read back to the physician 3 times by the Registered Nurse (RN #3). The next progress note was created by RN #4 with an effective date of 8/14/25 at 10:31 PM, that indicated that the Morphine order was not delivered, and a new order was entered after discussion with the physician to use the morphine available in the facility. A review of Resident #5's medical order on 10/27/25 at 11:51 AM confirmed that the initial order for morphine was 10mg/5ml with instructions to administer 5ml by mouth every 3 hours for pain. This order had a start date on 8/14/25 at 12 PM and was discontinued on 8/14/25 at 10:30 PM. The next order for morphine was 100mg/ml with instructions to administer 0.25ml every 3 hours as needed for pain. This order was started on 8/14/25 at 10:22 PM. On 10/28/25 at 9:28 AM a review of Resident #5's narcotic count sheets were conducted with the Director of Nursing (DON). The review revealed that both solutions (10mg/5ml and 100mg/ml) of morphine were delivered on 8/15/25. Further review of the narcotic count sheets revealed that the nursing staff had initially used the morphine solution with a stock dose of 10mg/5ml and pulled 0.25ml for each administration from 8/15/25 through 8/24/25, for a total of 22 times by different nurses. The DON reported that this solution of morphine should not have been delivered by the pharmacy since the order had been discontinued already and indicated that the nursing staff should have used the 100mg/ml solution initially. The DON confirmed during this review that Resident #5 had received the wrong dose of the medication. On 10/29/25 at 1:03 PM, the concern was discussed with the DON that the facility had failed to keep Resident #5 free from significant medication errors. The DON verbalized understanding and acknowledged the concern.</p>		