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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 03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lions Rehab Center	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on record review and interviews it was determined that the facility failed to provide a resident with reasonable accommodation of need. This was found evident in 1 (for Resident # 42) of 6 facility-reported incidents reviewed on the survey. The findings include: On 3/26/26 at 7:18 AM, the surveyor reviewed the facility's investigation file in regard to an allegation of abuse/neglect of Resident #42 by a staff member on 3/7/26. On further review a statement was written by Geriatric Nursing Assistant (GNA) #32 that stated while attempting to assist Resident #42 to the bathroom it was noted that his/her bathroom was under construction so a bed pan was given. Next the surveyor reviewed Resident #42's care plan. A care plan was created on 3/9/26 that stated, Resident #42 has Activities of Daily Life (ADL) self-care deficit. One of the interventions listed was to assist to the toilet/commode. Additionally, it stated Resident 42 needed maximum assistance of 1 staff for toileting. On 3/36/26 at 10:59 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON stated when Resident #42 was admitted to the facility, his/her bathroom was out of order due to the floor needing time to set as it was newly renovated. She further stated that a commode should have been available for Resident #42 to utilize while the bathroom was out of commission.

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 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 interviews, it was determined that the facility failed to ensure that a Resident's Responsible Party (RP) was notified of changes in a resident's condition. This was evident for 1 (Resident #96) of 3 residents reviewed for wound care during the survey. The findings include: On 3/24/26 at 10:48 AM, the surveyor reviewed a complaint and a facility reported incident into allegations that Resident #96 did not receive appropriate care. Next the surveyor reviewed Resident #96's medical record. The review revealed that on 12/5/25 the attending physician determined that Resident # 96 was unable to comprehend and make medical treatment decisions. On further review it was noted that Resident #96 had an Advanced Directive that named a healthcare power of attorney. In the progress notes the surveyor noted a wound provider documented seeing Resident #96 on 12/10/25 and addressed a new wound found on Resident #96 {genitalia}. The surveyor also noted a change of condition note written by Registered Nurse (RN) #34 on 12/10/25 regarding the new wound found on Resident #96's {genitalia}. In the section that documents that the Resident Representative (Responsible Party) was notified, RN #34 wrote, Resident is alert and oriented-refused to have family notified said thats (sic) my {genitalia} and I don't want to tell them. On 3/25/26 at 8:09 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor reviewed the concern that Resident #96's RP was not notified of the new skin conditions for Resident #96 and the PR had concerns about the treatment of wounds. The DON confirmed that the RP should have been notified when the new skin condition was found and the treatment that were needed.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on review of the facility's investigation report, record review, and interviews, it was determined that the facility failed to protect a resident from verbal abuse and neglect from an employee. This was found evident on 1 (Resident #42) of 4 Residents reviewed for abuse and neglect. The findings include:On 3/26/26 at 7:18 AM, the surveyor reviewed the facility's investigation file into the allegation that Geriatric Nursing Assistant (GNA) #31 verbally abused and refused to provide care to Resident #42. The conclusion to the investigation stated that the allegation was verified by evidence collected during the investigation.Next the surveyor reviewed the statement given by GNA #32. GNA #32 reported she was asked to help pull Resident 42 up in bed with GNA #31 on the morning of March 7th, 2026. While entering Resident #42's room, GNA #32 heard Resident #42 state It's been a long time since I have been asking you to help me use the toilet. Please, I need to pee, otherwise, I am going to pee myself and the bed. GNA #32 reported the response of GNA #31 was, And I told you that I am serving breakfast trays, so go ahead and pee the bed, I will clean you up. GNA #32 reported returning to her assignment and later returning to Resident #42's room to pick up breakfast trays. GNA #32 asked if #42 was done with his/her tray and he/she stated, I still need help to use the bathroom, I badly need to be, I think I started to wet myself.Further review of the investigation file had statements from Resident #6, Resident #49 and Resident #13, whom all stated they had concerns with how GNA #31 provided care and/or spoke to them. Resident #42 was not able to recall the incident.On 3/26/26 at 8:12 AM, the surveyor interviewed Resident #42 and confirmed that he/she would not remember the allegation on 3/7/36.On 3/26/26 at 8:21 AM, the surveyor interviewed Resident #13. During the interview Resident #13 stated that if he/she had ask GNA #31 for anything and he/she was in a bad mood GNA #31 would get upset and say, I hate my job. Resident #31 stated that he/she was scared to ask for help because he/she did not want to get GNA #31 all worked up.On 3/26/26 at 8:26 AM, the surveyor interviewed Resident # 6. During the interview Resident #6 stated that GNA #31 would offer to give a bath and stated that he/she would come back and would not return until the afternoon. Resident #6 also stated that GNA #31 would tell Resident #6 that he/she did not have time to change him/her and would do it when he/she came back. Resident #6 stated that he/she was scared to ask for things because he/she would be told no.On 3/26/26 at 8:32 AM, the Surveyor interviewed Resident #49. During the interview Resident #49 stated the GNA #31 would often tell him/her that he/she would be right back after checking in with Resident #49 in the morning and wound not come back until after lunch, even though he/she was wet and was dependent on staff for help. Resident #49 also stated that he/she heard Resident #13 yell in pain while being bathed by GNA #31 and heard GNA #31 tell Resident #13, I can't bathe you if you are like that. I don't have to bathe you. I can be taken off your assignment.On 3/26/26 at 9:35 AM, the surveyor interviewed GNA #32. During the interview GNA #32 confirmed that her statement was true.On 3/26/26 at 10:59 AM, the surveyor conducted an interview with The Director of Nursing (DON). During the interview the surveyor relayed the concerns that that GNA #31 verbally abused Resident #42 and walked away from providing cares. The DON stated that after the allegation GNA #31 was suspended and after the concerns were validated, fired. She also stated that GNA #31 was reported to the Board of Nursing and the abuse prevention education was completed by the staff after the investigation.

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F 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.

Based on observation, interviews and record reviews it was determined that the facility failed to review, update and revise Resident's care plans after Resident's changes in conditions. This finding was found to be evident in 2 (Resident #11 and #95) out of 13 Residents reviewed for care plan timing and revision. The findings include:Care plans are a written document that outlines a person's care needs and how they will be met. It's a key tool for health and social care professionals to ensure a Resident receives the right level of care. Care plan includes medical history, current treatments, and medications. Care plans should be reviewed regularly to monitor their effectiveness, and the Resident should be involved in the process. Additionally, care plans should be developed, revised and updated as necessary to reflect the Resident's condition by the interdisciplinary team. The care plan includes assessment, diagnoses, goals, interventions and outcomes. Care Plans are required to be developed within 7 days of completion of a Resident's admission comprehensive Minimum Data Set (MDS) assessment and revised at least every quarter (or more often as needed).

The surveyor observed Resident #11 in bed on 3/23/2026 at 1:26 PM with oxygen in use. Resident #11 was alert and oriented to person, place and time.

A record review of Resident #11's medical record was conducted by the surveyor at 9:05 AM on 3/25/2026. Record review revealed that Resident #11 had a physician order for oxygen at 2 Liters/minute via nasal cannula every 24 hours as needed for shortness of breath dated 2/19/2026, and continuous oxygen every shift dated 3/5/2026. Further review of the medical record revealed that oxygen usage was not indicated on Resident #11's care plan.

In an Interview with the Director of Nursing (DON) at 10:30 AM on 3/26/2026 the surveyor conveyed that Resident #11 had orders for as needed and continuous oxygen, but review of the care plan did not reveal that oxygen usage was addressed on any of the Resident's care plans. DON stated that Resident #11 was new to the usage of oxygen. The surveyor asked what the expectation for the care plan update and revision was when a Resident had a new order for oxygen, and the DON stated that the care plan should have been updated for oxygen usage.

No additional information was provided by the facility at the time of survey exit.

On 3/25/26 at 9AM, the surveyor reviewed Resident #95's medical record. The review revealed Resident #95 was admitted to the facility in early February of 2026 and transferred to a hospital after a fall on 2/12/26.

On further review a progress note written by Registered Nurse (RN) #33 stated, Resident #95 was found on the floor after falling out of bed on 2/9/26. The note stated that fall protocol was initiated.

Next the survey reviewed Resident #95's care plan. A care plan initiated on 2/5/26 stated Resident #95 was at risk for falls. After the fall on 2/9/26 an additional intervention was updated on 2/10/26 and stated, to monitor side effects of medication. On further review of Resident #95's care plan, the surveyor noted a care plan initiated on 2/16/26 that stated, Resident #95 was at risk for falls related to history of falls, gait and transfer dysfunctions, fatigue or weakness, new environment, impaired safety awareness/cognition loss and unsteady gait. This was entered after the 2nd fall.

On 3/25/26 at 3:12 PM, the surveyor conducted an interview with the Director of Nursing (DON).
(continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview the surveyor asked what steps were completed after a resident fall. The DON stated that after a fall the facility investigates the reason for the fall and addresses the issues. She further stated that care plans are updated as needed. The surveyor reviewed the care plan with the DON and pointed out that the care plan written after the second fall had the same conditions present after the first fall, however, it was written only after the 2nd fall. The DON agreed that the actual fall was not captured in the resident's fall care plan revised on 2/10/26.

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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 reviews and interviews it was determined that the facility failed to provide treatments according to a Resident's plan of care. This was found evident of 1 (Resident #96) out of 3 residents reviewed for wound care. The findings include: On 3/24/26 at 10:48 AM, the surveyor reviewed Resident #96's medical records. A review of Resident #96's December Treatment Administration Record revealed that on 12/10/25 an order was written that stated, apply skin guard ointment to {genital area} and coccyx every day and evening shift for skin healing. The order was documented as completed on the evening of 12/10/25 and morning and afternoon on 12/11/25. The order was discontinued on 12/11/25. A new order was written to start on 12/12/25 that stated apply skin guard to {genital area} every day and evening shift for wound healing. However the new order did not include the orders to apply the treatment to the coccyx. A new order for the coccyx wound was written to start on 12/17/25 and stated, to cleanse with wound cleaner, apply medi-honey to the wound bed and cover with a border foam dressing as needed for wound care. On 3/24/26 at 1:50 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor reviewed the concern that would care for Resident #96's coccyx wound was not ordered or documented as provided 12/12/25-12/17/25 until a new order was written on 12/17/25. The DON stated she would look for wound care documentation. At the time of exit no additional documentation was provided to the surveyor.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record reviews and staff interviews, it was determined that the facility failed to ensure medications were administered to a resident as ordered. This was evident for 1 (Resident #70) out 47 residents reviewed during the survey. The findings include: On 3/26/26 at 12:13 PM, the surveyor reviewed Resident #70's medical record. The review revealed that Resident #70 had an order changed on 3/14/25 for lorazepam (a benzodiazepine used to treat anxiety disorders and acute seizures) to be changed from every hour as needed to scheduled twice a day, due to an increase in behaviors. Depakote (an anticonvulsant and also used as a mood stabilizer) was also prescribed to be given twice a day for behaviors and agitation on that same day. Next the surveyor reviewed Resident #70's March 2026 Medication Administration Record (MAR). The review revealed that Resident #70's lorazepam was left blank, indicating the medication was not given, on the afternoon dose of 3/14/26 through the morning dose of 3/19/26, in which the medication was discontinued in the afternoon. However, the depakote order was coded as not available on the afternoon dose on 3/14/26 but documented as administered as ordered the days following. On review of the progress notes it was noted that lorazepam was not given on 3/16/26 due to, waiting for medication to be delivered, on 3/17/26 not given due to prescription not signed by provider, and again on 3/19/26 not given due to order was not signed by provider. Additional notes written on 3/17/26 at 11:36 documented the lorazepam was given as order, and also on 3/18/26 at 11:53 AM and 7:40 PM it was documented as given. However, these administrations were not documented on the March administration record. On 3/26/26 at 1:47 PM, the surveyor interviewed the Director of Nursing (DON). During the interview the surveyor reviewed the missing doses of lorazepam for Resident #70 and asked why the medication would not have been administered as ordered. The DON stated that if the medication order was not signed by the provider, then the pharmacy would not release the medication. The surveyor showed the DON that some of the progress notes stated that the medication was given however nothing was documented on the MAR. The DON stated that the medication should have been given as ordered and if the provider needed to sign the prescription, then the staff should have talked to the provider and gotten a signature. She further stated she would look for additional documentation to indicate if the medication was given on the days documented as given. At the time of exit no additional documents were provided to the surveyor.