

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/06/2026
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)		
F 0757 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on the review of a facility reported incident interviews, medical record review and review of facility policy, it was determined that the facility staff failed to ensure that medication was administered correctly. These failures led to the findings of actual harm to Resident #7. This was evident during the review of 1 of 1 Residents (#7) The findings include: Brief interview for mental status (BIMS) used to determine the individual's attention, orientation and ability to register and recall new information. Resident #7 was admitted to the facility with an assessed BIMS of 15, meaning that s/he was cognitively intact and would verbalize his/her needs and was self-directed in activities. Review of the facility reported incident 3013734 on 9:40 AM on 6/26/26 revealed an incident occurring on 5/13/26 where LPN #5 had prepared medications for the resident in bed 'A.' However, when she went in the room, the resident bed 'B' had a beverage spill, so she reportedly became distracted, went to bed 'B' to assist and set the cup of prepared medication for bed 'A' down on the bedside table assigned to bed 'B.' Once the mess was cleaned, she then gave the medications sitting on the bedside table for bed 'B' to resident in bed 'B,' Resident #7. LPN #5 proceeded to the hall like normal to sign off the administered medications and immediately noted the medication administration error. She checked on Resident #7 and notified the attending physician around 7:55 AM that at 7:45 AM she gave the resident the wrong medication. Not long after at approximately 8:10 AM, Resident #7 was wheeled into the hall for an appointment scheduled at 8:30 AM, and was noted to become lethargic with head drooping and became unresponsive. A call and subsequent order was placed for Resident #7 to be sent to the emergency room for further assessment and monitoring. Resident #7 was documented to arrive at the hospital with treatment in place by 9:00 AM on 5/13/26. According to the hospital admission records reviewed on 6/29/26 at 1:45 PM revealed that Resident #7 was in appropriately administered the roommate's Clozapine 100 mg, (an atypical antipsychotic that requires careful monitoring including lab work on prescribed individuals), and Amantadine 100 mg which can cause confusion and is filtered in the kidneys, potentially detrimental for someone with Kidney cell carcinoma which Resident #7 had. Upon arrival at the hospital resident Glasgow Coma Score (GCS) was 4. GCS is a clinical scoring tool used to objectively measure a person's level of consciousness and assess the severity of acute brain injuries. Scores range from 3, deep coma or death to 15, fully awake. Secondary to Resident #7's Do Not Resuscitate status, s/he was not intubated. On admission to the hospital, the diagnosis included adverse effects of drugs. Poison control was consulted by the emergency room and recommended supportive management as no antidote was available. The resident was hypotensive with blood pressure 70/40's. The resident was managed in the ICU for pancytopenia (a dangerous medical condition characterized by a shortage of all three major types of blood cells, though rare, a serious side effect of Clonazipine) requiring multiple transfusions, hypotension and hypothermia over the next several days as well as requiring norepinephrine (a strong vasoconstrictor to treat low blood pressure and shock) and IV fluids and (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
--	-------	-----------

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 07/06/2026
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)		
F 0757 Level of Harm - Actual harm Residents Affected - Few	received antibiotics along with transfusion support (blood products) for anemia (low blood count). Lab work, including complete blood counts that would show signs of pancytopenia, reviewed on 6/29/26 at 3:32 PM from Resident #7's admission to the facility revealed s/he was stable prior to this hospital admission. Resident #7 began to regain some mentation on 5/14/26, however after discussion with the POA and palliative care team, Resident #7 was placed on comfort measures only, with focus on symptom management. On 5/15/26 s/he continued with documented lethargy and required more blood transfusions. The facility was notified on 6/29/26 at 2:55 PM of the severity of the identified concerns of LPN #5 administering the incorrect medications to Resident #7 who then required a higher level of care including the use of resuscitative interventions after those medications were administered. At this time the facility DON reviewed the training the facility implemented and the new policy they developed on 5/13/26 for the 10 resident rights of medication administration. The education further elaborated into avoiding distractions as was the root cause determined in this incident. LPN # 5 received individual education from the facility ADON. The DON stated that the unit managers are supposed to be completing observations and audits of staff completing medication passes. The DON stated that all staff were educated on the facility policy of the 10 rights of medication administration, this was done by pop up educational in-services. A review of LPN #5's file, on 6/26/26 revealed that she was up to date on all of her training and education and had not had any other write ups or concerns in the past related to resident care or medications administration.		

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 07/06/2026
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)		
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 record review and interview, it was determined that facility staff failed to ensure residents were free from abuse. This was evident for 1 (#1) of 4 residents reviewed for abuse. The findings include: On 6/26/26 at 10:59 AM a medical record review for Resident #1 revealed no evidence that the resident lacked capacity to make decisions. A review of the care plan revealed that on 10/21/25 a focus for the resident's hoarding behavior was initiated. There were interventions initiated on 10/21/25, however, no revisions since that time. A review of the psychiatric nurse practitioner (NP) #12's notes between 9/25 to time of survey revealed the resident had a generalized anxiety disorder. On 5/1/26 NP #12 documented he was visiting the resident due to staff concerns with the resident hoarding things. He documented that the resident reported they were keeping the stuff to sell and there were no interventions for the hoarding behavior suggested. A review of the attending physician's note for a visit conducted on 5/2/26 revealed no psychiatric concerns were documented. On 6/26/26 at 10:00 AM a review of the facility's investigation file for the facility reported incident #3026098 was conducted. A review of the initial report form revealed that on 5/27/26 the facility reported to the State Agency (SA) an allegation of abuse for Resident #1. The report documented that Resident #1 reported that when s/he returned from an appointment on 5/18/26, s/he was approached by staff to help clean out their room. The resident reported that during this room clean out s/he was injured by the Nursing Home Administrator (NHA) while struggling over a bag of food they were trying to throw away. The resident reported that it was a container of food that s/he purchased after their appointment earlier that day. A review of the statements provided by the staff who were present during the room cleanout revealed that when they started to throw away the resident's spoiled food containers that s/he became increasingly upset and anxious. At some point, the NHA came to the room to assist because the resident was yelling and screaming. He reported that he asked to see the food s/he was claiming to have bought that morning and it appeared to be moldy. While the NHA administrator was telling the resident they could not allow him/her to consume the moldy food, the resident attempted to grab the bag from the NHA. They struggled over the bag of food, causing it to rip and the contents to fall on the floor. The NHA documented that he became frustrated and handed the resident a \$20 bill to cover the cost of the food and left the room. The final report documented Resident #1 reported that s/he had developed bruises on both wrists and facility staff assessed and documented the bruises. During an interview with Resident #1 on 6/26/26 at 10:27 AM, s/he reported that the bruising had come from the altercation with NHA #1 and that s/he became very angry every time s/he had seen him since. The Administrator in Training (AIT) was interviewed on 6/29/26 at 12:52 PM. She stated that she had assembled a team of staff to go to Resident #1's room on 5/18/26 to assist the resident to clean up due to some other residents complaining. She stated the resident was agreeable at first, but then as they were throwing spoiled food away, Resident #1 became belligerent. She reported that since she was not the Administrator, she asked someone to ask the NHA to come to the room. She stated that she witnessed the NHA telling the resident s/he was not allowed to have the spoiled food to consume and a struggle between the NHA and the resident over a bag of food occurred causing the contents to be spilled on the ground. She reported that she would not have handled the situation in that manner. She reported she did not think that abuse occurred because the NHA never touched the resident. Then the resident reported an allegation of abuse on 5/26/26 to her, the Regional Director of Clinical Services Staff, and the Social Services Director. The resident alleged that s/he was bruised during the altercation over the bag of food, (continued on next page)		

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 07/06/2026
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)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	however, since the AIT was present during the incident, she failed to report the allegation of abuse. Furthermore, there was no assessment of the resident's injuries at the time of the allegation. An interview with the Social Worker (SW) on 6/26/26 at 12:06 PM revealed that she was asked by the AIT to be a witness to the room clean out for Resident #1. She stated that when staff started throwing away the resident's food containers, the resident became belligerent. She was asked by the AIT to get the NHA to assist. When he came into the room, the ADON was handing the resident a bag of food that had been thrown in the trash, and he took the bag from the resident. She reported that she heard the NHA tell the resident that he, the NHA, was not going to allow him/her to consume spoiled foods. She stated she did not see exactly what happened next but a struggle between the two occurred over the bag of food. The bag broke and the contents spilled on the floor. She stated the NHA took money out of his pocket and handed it to the resident as payment for the food. When asked if she had concerns about the interaction, she stated they all had concerns and talked afterward. When asked why this was not reported, she stated that it was witnessed by the AIT. An interview with Assistant Director of Nursing (ADON) on 6/26/26 at 1:09 PM revealed that she was present in the room during the attempt at cleaning the Resident #1's room on 5/18/26. She reported the same incident as the other staff. When asked why she had not reported the incident, she stated that she knew the NHA did not mean any harm. However, she admitted to being taken aback by what she had witnessed and if she had seen that with any other staff member she would have removed them from the unit and reported abuse. An interview with the NHA on 6/30/26 at 2:25 PM revealed that he was called to Resident #1's room on 5/18/26 because staff found spoiled food in the room and the resident was upset that they were throwing it out. He stated that when he got to the room, he asked to see the bag of food the resident was reporting that s/he had just purchased that day. He stated that he looked at it and it had what appeared to be mold growing on it. He stated that he told the resident that she could not have the food because it was spoiled. He stated that the resident was upset and yelling and they struggled over the bag of food. This caused the bag to tear, and the content spilled on the floor. When asked if the resident was capable of making his/her own decisions, he stated that the resident was capable, but he was not going to allow the resident to eat spoiled food. The Director of Nursing (DON) was interviewed on 6/26/26 at 12:08 PM. She reported she had no knowledge of the events that occurred on 5/18/26 or the allegation of abuse that was reported on 5/26/26. She stated that when she received the allegation of abuse on 5/27/26, she went to the Regional Director of Clinical Services. She reported she did so because it involved the NHA. An interview with the Regional Director of Clinical Operations on 6/29/26 at 1:52 PM revealed she was present at the meeting on 5/26/26 with the resident, the AIT and SW. She stated that the resident was complaining about the altercation with the NHA, but she doesn't recall the resident talking about being bruised. However, she talked with the staff members who were present, to include the NHA, and she decided that the allegation of abuse had not warranted a report to the SA. The next day on 5/27/26 when the resident reported the same allegation of abuse to the Maintenance Director, it was then reported. When asked what the difference was between what was reported on 5/26/26 to what was reported the next day, she stated it was the context. She further stated that she does not report all allegations of abuse because it can hurt people, she stated she investigates them first to determine if they should be reported or not. Cross Reference: F609		

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 07/06/2026
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)		
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on the review of a facility reported incident 3054507, medical record review, interview with facility staff, it was determined that the facility failed to ensure that residents medications were secure, maintained and free from misappropriation. This was evident for 1 of 2 (9) residents reviewed for medication misappropriation during a complaint survey. The findings include: Brief interview for mental status (BIMS) used to determine the individual's attention, orientation and ability to register and recall new information. Resident #9 was recently admitted to this facility for rehabilitation and pain management. S/he was assessed on admission as having a BIMS of 15, meaning that s/he is cognitively intact. Resident #9 was also noted as his/her own responsible party. Review on 6/30/26 at 11:50 AM of the facility reported incident 3054507 occurring on 6/21/26 during the 7:00 PM shift change between LPN#6 who was leaving and LPN #17 who was returning after leaving that morning. When the narcotic count was completed on shift change that morning between LPN #6 and LPN #17 there were no noted discrepancies. However, upon LPN #17's return, when the count was completed, there were 2 controlled substances missing and unaccounted for. The Unit manager and DON as well as the patient were notified and the facility was searched for the missing medication, however it was not located. LPN #6 was suspended during the investigation. The DON's documented investigation and interviews with LPN #6 in the facility investigation packet revealed that LPN #6 who was responsible for the medications at the time they went missing, self-reported to have a history of leaving both the medication cart and the secure narcotic box unlocked and unmonitored while in charge of said medication cart. LPN #6 was terminated from the facility. Record review of Resident #9's medication administration record (MAR) as well as interviews with the resident on 6/30/26 at 11:50 AM revealed that s/he did not miss receiving the administration of any medication and further had no verbal effects of pain from potentially missing medication from this incident. The DON was interviewed on 6/30/26 at approximately 1:00 PM regarding the missing medications. She verbalized that the facility replaced the medications and that the resident never went without pain medication. The concern that a controlled medication went missing and the LPN admitted to not following the facility policy, after a new policy was implemented on 5/13/26 was reviewed. We reviewed the training at this time and LPN #6's name was on the education sign in sheet from the 5/13/26 in-service for Safe Medication Administration Guide which included storing medications safely.		

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 07/06/2026
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, it was determined that facility staff failed to report all allegations of abuse to the State Agency (SA) as required. This was evident for 1 (#1) of 4 residents reviewed for abuse. The findings include: During an interview with Resident #1 on 6/26/26 at 10:27 AM, s/he reported that the bruising had come from the altercation with NHA #1 and that s/he became very angry every time s/he had seen him since. During an interview with the Administrator in Training (AIT) 6/29/26 at 12:52 PM regarding the facility reported incident #3026098, she reported that she had witnessed a verbal and physical altercation between Resident #1 and the Nursing Home Administrator (NHA) on 5/18/26. She stated she failed to report this altercation as abuse because she knew that the NHA had no ill intentions. She further reported that during a meeting with Resident #1, the Social Services Director, and the Regional Director of Clinical Services, the resident reported that s/he had bruising on both wrists from the physical altercation with the NHA. She stated that she failed to report the allegation of abuse because she had been present during the altercations and the bruises had not come from the altercation. An interview with the Social Services Director on 6/26/26 at 12:06 PM revealed that she was present during the room clean out and witnessed the verbal and physical altercation between the resident and the NHA. She reported she had concerns about the interaction, she stated they all had concerns and talked afterward. When asked why this was not reported, she stated that it was witnessed by the AIT. In addition, she reported she was at the meeting on 5/26/26 with the AIT and Regional Director of Clinical Services and heard the allegation of abuse from Resident #1. She thought that it was reported to the SA after the meeting. An interview with the Regional Director of Clinical Operations on 6/29/26 at 1:52 PM revealed she was present at the meeting on 5/26/26 with the resident, the AIT and SW. She stated that the resident was complaining about the altercation with the NHA, but she doesn't recall the resident talking about being bruised. However, she talked with the staff members who were present, including the NHA, and she decided that the allegation of abuse had not warranted a report to the SA. On 6/26/26 at 10:00 AM a review of the facility's investigation file for the facility reported incident #3026098 was conducted. A review of the initial report form revealed that on 5/27/26 at 11:00 AM the facility reported to the State Agency (SA) an allegation of abuse for Resident #1. The report documented that Resident #1 reported that when s/he returned from an appointment on 5/18/26, s/he was approached by staff to help clean out their room. The resident reported that during this room clean out s/he was injured by the Nursing Home Administrator (NHA) while struggling over a bag a food they were trying to throw away. The resident reported that it was a container of food that s/he purchased after their appointment earlier that day. A review of the statements provided by the staff who were present during the room cleanout revealed that when they started to throw away the resident's spoiled food containers that s/he became increasingly upset and anxious. Based on the NHA's statement, at some point he came to the room to assist because the resident was yelling and screaming. He wrote that he asked to see the food the resident was claiming to have bought that morning and it appeared to be moldy. While the NHA administrator was telling the resident they could not allow him/her to consume the moldy food, the resident attempted to grab the bag from the NHA. They struggled over the bag of food, causing it to rip and the contents to fall on the floor. The NHA documented that he became frustrated and handed the resident a \$20 bill to cover the cost of the food and left the room. The final report documented Resident #1 reported that s/he had developed bruises on both wrists and facility staff assessed and documented the bruises. On 7/1/26 at 1:18 PM the concerns were reviewed with the AIT and Regional Director of Clinical Services. Cross Reference: F600		

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 07/06/2026
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)		
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observation, resident interview, record review, and staff interview, it was determined that facility staff failed to ensure that residents had behavioral health services to help achieve their highest practical level of functioning. This was 1 (#1) of 1 resident reviewed for behavioral health concerns. The findings include: Diagnostic and Statistic Manual of Mental Disorders V - the following criteria for hoarding disorder: Persistent difficulty discarding or parting with possessions, regardless of their actual value. This difficulty is due to a perceived need to save the items and to distress associated with discarding them. The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities). The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for self and others). The hoarding is not attributable to another medical condition (e.g., brain injury, cerebrovascular disease, Prader-Willi syndrome). The hoarding is not better explained by the symptoms of another mental disorder (e.g., obsessions in obsessive-compulsive disorder, decreased energy in major depressive disorder, delusions in schizophrenia or another psychotic disorder, cognitive deficits in major neurocognitive disorder, restricted interests in autism spectrum disorder). Care plan - is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Person-centered care: means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives. During an observation on 6/26/26 at 8:15 am of Resident #1, the resident was observed asleep in bed. There was a breakfast tray sitting on a rollator as there was no room to place it on the over-the-bed table or bedside stand. Due to the items piled up in the room, there was no pathway to get to the over-the-bed table or the bedside stand. There was approximately a 30 to 45 degree angled path from the middle of the bed to the foot of the bed that opened to the center of the room, however, there was no straight path to the head of the resident's bed. On the right side of the bed was a rollator walker holding the breakfast tray and behind it was a dresser that was completely covered with items. There were 3 reusable shopping bags full of items sitting in front of the window. There were other items that were so many it was difficult to identify them that filled the space between the bags and the bedside stand. A medical record review on 6/26/26 at 10:59 AM for Resident #1 revealed the resident was admitted in May 2025. A review of the care plan revealed on 10/21/25 Registered Nurse (RN) #8 initiated a care plan for hoarding behaviors. The goal was that the resident's inappropriate behaviors will be managed with minimal stress for the resident and others, which was not a resident-centered goal. The interventions were all initiated at the time of the care plan was developed and included the following; distract the resident with conversation, singing, something warm and comforting to hold, etc.; document behaviors and effectiveness of interventions before using medications; monitor behavior for clues; look for time, location, activity at time, environmental factors, others and their responses; set limits prior to provision of care; explain/review what behavior is appropriate and inappropriate; and Social Worker to visit with resident and/or family as needed. Further review of the care plan meeting notes, physician visit notes, Psychiatric Nurse Practitioner Staff #12's visit notes for 9/16/25, progress notes dates 10/1/25 - 10/21/25, nursing assistant behavior documentation and the medication/treatment administration records for 8/25, 9/25, and 10/25 revealed no evidence as to why the hoarding care plan was initiated. A review of (continued on next page)		

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 07/06/2026
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)		
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychiatric consult notes, since the time of admission to current, revealed the resident was visited by a psychotherapist and a Licensed Certified Social Worker - Clinical, however, there was no indication in their notes that the resident was receiving therapy for hoarding behaviors. The visits were conducted by telehealth; therefore, they had not been in the resident's room to observe the hoarding behaviors. A visit conducted by Staff #12 on 5/1/26 revealed that facility staff had a concern with the resident's hoarding behavior. However, there was no documentation regarding what he observed in the resident's room. He stated the resident denied hoarding behaviors and stated s/he was keeping the items to sell later. Staff #12 documented on 6/5/26 that he was asked to see the resident due to staff to patient conflict, however, there was no indication in the notes that he had discussed with the resident what occurred during the conflict and noted that the resident was not in psychosocial distress. A review of facility investigation file for a facility reported incident #302098 dated 5/27/26 revealed that on 5/27/26 Resident #1 alleged s/he was injured during an altercation with the Nursing Home Administrator over some bags of food. The final report stated that management approached Resident #1 as a team to assist him/her with cleaning out their room. On 6/30/26 at approximately 2:50 PM an interview with Resident #8 revealed s/he was residing in the same room as Resident #1. The resident reported that while they got along with Resident #1, the clutter coming to his/her side of the room, the smell, the pest that the stored food attracted was too much. Resident #8 reported that s/he had asked for a transfer and when s/he was told there were no other rooms available she requested to move to another facility because the living conditions were so bad. An interview with certified nursing assistant II (Aid) #9 on 7/2/26 at 9:34 AM revealed that she could not recall when Resident #1's hoarding behaviors became apparent. She stated that upon admission the resident would not allow them to take his/her meal tray until the next one was delivered. She stated that this posed an issue in the evenings since there were no more trays until breakfast and would result in the resident having a meltdown by yelling and screaming at staff. She stated that they would report to the nurse, but when they tried to intervene the resident would become argumentative and hostile with them. She stated at some point the resident was accumulating so much stuff in his/her room and staff were unable to figure out where the resident was getting the stuff from because the resident had not had many visitors. She reported the resident was observed by another certified nursing assistant getting into a van in the parking lot and taking stuff out. Aid #9 recalled the first time she observed the van in the parking lot, she could see in the windows and now she couldn't. Aid #9 reported that more recently NHA #1 and the Administrator in Training (AIT) had told the resident a timeframe that s/he had to clean out the stuff in his/her room. She reported that the resident's meltdowns had become more frequent in the past month. She reported she had not had training on hoarding or how to deal with these behaviors. During an interview with Aid #14 on 6/30/26 at 1:00 PM, she reported that Resident #1 was hoarding shortly after arrival in May 2025. She was unsure when the resident's van was brought to the facility. She stated that she and other staff were concerned about the resident's safety due to the amount of things s/he had collected. When asked about training, she reported there had been no training given on how to deal with the resident's behaviors. An interview on 7/2/26 at 10:05 AM with Registered Nurse (RN) #10 revealed she was unable to recall when the resident's hoarding became an issue or when the van showed up. She stated that she was aware of the issue with food hoarding since admission. She stated that it was after the resident was transferred to a 4-person room that his/her things started to pile up. She reported the same behaviors regarding food that Aid #8 reported. When asked about the van, she reported that once they noticed the van the resident seemed to be accumulating more items in the room. RN #10 reported that the resident had meltdowns with screaming and yelling but does not always share the reason and would (continued on next page)		

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 07/06/2026
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)		
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	become hostile when asked. She failed to document these behaviors in the resident's medical record. She reported that she thought the resident was being seen by Psychiatric Nurse Practitioner Staff #12 for hoarding behaviors, however based on the notes and interviews this was not the case. She reported the facility had not given any training on how to deal with the resident's behaviors. During an interview with RN #8, who was the MDS nurse, on 7/2/26 at 10:36 AM she reported that she was not certain why she had initiated the care plan for hoarding. She stated it was possible it was a result of discussing the resident during the facility staff's morning clinical meetings. She reported she had little knowledge of the resident's behaviors and when they started. The interventions listed on the care plan were reviewed and she reported that they were generalized interventions that had not been customized for the specific resident. When asked if she was responsible for updating the care plan, she reported updates were done by the care plan team. An interview on 7/2/26 at 10:58 AM with ADON #11 revealed she was part of the care plan team. She stated she was responsible for reviewing the resident's care plans, goals, and interventions to prepare for the quarterly care plan meetings. She could not recall when the facility identified Resident #1's hoarding behaviors or when the resident's van showed up. The Director of Nursing (DON) reported on 6/30/26 at 2:00 PM that she took a stand off approach to the concerns with Resident #1's hoarding behavior. Further reporting that she had not wanted any nursing staff involved, but the Nursing Home Administrator (NHA) kept asking the floor nurse, who was frequently assigned to the resident, to help intervene. She stated that she felt it was more of a safety issue and not a clinical issue. An interview with the Social Services Director Staff #16 on 6/26/26 at 12:06 PM revealed she was unaware as to whether Resident #1 had been diagnosed with hoarding or not. She reported she thought that Psychiatric Nurse Practitioner #12 was working with the resident regarding the hoarding behaviors. She stated she does not provide counseling to the residents because they have a contractual Licensed Certified Social Worker (LCSW). When asked about the incident that occurred on 5/18/26, when staff attempted to clean out the resident's room and the resident was crying and screaming, according to multiple written statements from staff. She reported she was not there to support the resident in a social services capacity, but to act as a witness for administration. Furthermore, prior to the 5/18/26 incident and after, the Social Services Director failed to report the hoarding behaviors and the resident's responses to staff when they tried to intervene to Psychiatric Nurse Practitioner #12 or to the LCSW to ensure the resident's mental illness/behavioral health concerns were addressed. During an interview with the Nursing Home Administrator (NHA) on 6/30/26 at 2:25 PM, he reported that some staff had gone to the resident's room on 5/18/26 to help the resident clean out the unsafe things that were in the room. He reported that some people thought the resident was a hoarder. He stated that when the resident did not allow staff to throw away spoiled food, he went in to intervene. During which time he reported the resident was yelling and screaming and a back and forth occurred over a bag of spoiled food. He stated that he was aware the resident had capacity to make his/her own decisions, but told them he was not going to allow them to consume spoiled food. An interview with Psychiatric Nurse Practitioner Staff #12 on 7/2/26 at 8:55 AM revealed that he relied on information provided by facility staff when they requested a consult from him. He reported that he was able to diagnose residents with mental disorders. He stated that he was asked once to see Resident #1 for hoarding behaviors. At that time, he noticed the resident had boxes piled to the ceiling, however, because the resident denied that s/he was hoarding he did not offer treatment. He admitted that people with hoarding often deny that they have an issue. He reported that staff had not informed him that the resident often had meltdowns with screaming and yelling when staff attempted to remove items from his/her room. He was informed of the incident that occurred on 5/18/26, when staff (continued on next page)		

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 07/06/2026
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)		
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attempted to throw out spoiled food and described the resident as becoming belligerent and refusing to allow them to continue and ultimately resulted in the resident screaming and crying and trying to take a bag of food back. He stated with this information he would have diagnosed the resident with hoarding, prescribed a serotonin reuptake inhibitor (a psychotropic medication that will help the resident's underlying condition causing the hoarding) and prescribe cognitive behavioral therapy. During a subsequent interview with the DON on 7/6/26 at 1:47 PM she was asked why nursing staff failed to document the hoarding behavior. She was informed of the locations the surveyor had reviewed in the medical record. She stated that she was unaware that the certified nursing assistants behavior charting included a code for hoarding behavior. She stated that her expectation was for nursing staff to document the behaviors on the medication or treatment administration record or write a progress note. She reported that they will add a resident's name to a hot charting list, which meant the nurse was to document behaviors every shift for 72 hours. She agreed this information was vital to help medical providers make diagnoses and provide treatment as needed. In addition, she reported that nurses assigned to the residents were expected to update care plans, however, she thought there was a lack of training on how to access and update them. She reported this may be the reason staff failed to update the resident's care plan with behaviors and create interventions to help the resident. An interview with the Administrator in Training (AIT) revealed she was aware of the hoarding and that it had been going on for a long time. She stated that when the NHA asked staff to intervene she thought she would assist with the process and formed a team to go to the resident's room and help the resident clean out. She reported on 5/18/26 when they went to the resident's room to help clean up, the resident had spoiled food stored in bags in the room. She stated the resident became belligerent and upset when they tried to get rid of the food, even though it was not safe to keep it. She reported that there was a bag of food that was moldy and the resident insisted that s/he bought the food that morning at the hospital. The resident tried to pull the bag away from the NHA and was screaming and yelling at him. However, the 5 staff members (AIT, NHA, ADON, RN, and Social Services Director) who were present during the 5/18/26 incident failed to report this information to the Psychiatric Nurse Practitioner Staff #12 when he was asked to see the resident after the incident.		

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 07/06/2026
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)		
F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, record review, and interview, it was determined that facility staff failed to follow the physician's ordered therapeutic diet for their residents. This was evident for 1 (#5) of 1 resident reviewed for dietary services. The findings include: On 6/26/26 at 8:35 AM an observation of Resident #5 revealed the resident was sitting in a chair in his/her room and the aid was setting up the resident's breakfast tray. The resident had pureed cereal with milk, a pureed biscuit, and regular scrambled eggs. A medical record review for Resident #5 on 6/26/26 at 8:51 AM revealed in the orders tab a physician's order that stated, Consistent Carbohydrates diet, Dysphagia Mechanical Soft texture, Regular consistency and no bread or crunchy foods. The order was dated 2/20/26. A review of the meal tickets for 2 weeks prior to 6/29/26 for Resident #5 on 7/1/26 at 12:48 PM revealed the resident's diet was listed at the top of the slip, however, the instructions for no bread or crunchy food were not included. Further review revealed there were meals that had pureed breads or bread-like products included on the meal ticket. However, on 6/26/26, the day the surveyor observed the resident breakfast tray, the resident's meal ticket showed s/he was to be served a cup of fresh fruit and no biscuit. On 7/1/26 at 9:20 AM an interview with the contracted dietary company's Regional Dietitian revealed that when a resident's orders state no bread or crunchy foods then there should be no breads to include pureed breads. She stated that these types of directives usually were from a speech therapist and were to be followed. The Dietary Manager was interviewed on 7/2/26 at 2:01 PM with the Administrator in Training (AIT) present. He reported that he was not sure why it did not show up on the ticket that there should be no bread or crunchy foods for the resident. He stated that sometimes with meal tracker he will mark no breads, but some breads would still show up on the meal tickets. The AIT was made aware of the concerns at this time.		

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 07/06/2026
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)		
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observations and interviews, it was determined that the facility failed to post nursing staffing for the entire building. This was observed during the survey. The findings include: On 6/26/26, at approximately 8:04 AM, an observation of the facility's main lobby was conducted. There was no observed staffing posted at the time. Continued tour and observations of the facility revealed that there was construction in progress where the main desk in the front entrance was no longer present and makeshift tables were in place where the nurses would sit throughout the day to document. There was no observed staffing posted at this time, nor were there any noted posted throughout the remainder of the facility. The survey team, upon entrance and meeting with the facility DON and NHA, requested staffing schedules for 06/26/26 and the following week. A review of these schedules revealed that the rooms assigned to the staff are not always filled in. Additionally, the print on the schedule included the entire day's schedule, day, evening and night on the front of the page, equating to over 40 lines of staff to sift through to determine who is caring for which resident. A normal sheet of notebook paper that is college ruled has a max of 34 lines, while wide ruled paper has a max of 24 lines for reference. On 6/30/2026 at 10:20 AM a staff schedule was observed posted in the lobby area by the makeshift nurse desks on a cart where the medical charts were stored. It was the same type of schedule provided to the survey team, secondary to the small font, the schedule remained illegible from regulatory standpoints. Continued observations of the nursing stations at the back of the facility failed to display any type of schedule. GNA #18 was interviewed on 6/30/26 at 10:35 AM regarding the lack of posted staff schedules and assignments. He stated that there used to be a board on the wall, where there are now two pictures of boats. So now they just lay it down at the nurse's station. During this time the maintenance director was walking by. GNA #18 asked him, 'what happened to the boards.' The maintenance director replied that they must have come down during all the renovations. The facility ADON was then interviewed at 10:37 AM. She stated that the form the surveyors were shown at this moment was for the in-house staff to use and she was not sure if that was for posting for the residents/visitors/families to use but did say the boards were ordered. This surveyor spoke with The Regional Nurse Consultant at 10:45 AM on 6/30/26 regarding the observations and findings. She verbalized understanding and referred this surveyor to the posting on the cart with the resident medical charts. The identified concerns with the legibility for all, as well as the concern of the lack of posting in all required locations was reviewed at this time and again during exit.		