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	03/27/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews it was determined that the facility failed to maintain a safe/clean/comfortable/homelike environment for Residents. This finding was found to be evident in 2 (Resident rooms [ROOM NUMBERS]) out of 15 Resident rooms and in review of an adequate supply of linen which has the potential to affect all Residents in the facility. The findings include: On 3/23/2026 at 10:45 AM the surveyor observed that the call light panel cracked in the Resident shared bathroom of room [ROOM NUMBER]. In the Resident shared bathroom of room [ROOM NUMBER] at 10:55 AM on 3/23/2026 the surveyor observed a large crack in the cover to the ceiling light. In an interview with the Regional Maintenance Director at 9:20 AM on 3/26/2026, the surveyor conveyed that the call light panel and the ceiling light cover were cracked in Resident shared bathrooms on the 300 hall. The Maintenance Director toured the 300 hall with the surveyor and observed the cracked call light panel in room [ROOM NUMBER], and the cracked ceiling light cover in room [ROOM NUMBER]. The Maintenance Director stated that he would get right on fixing these items. In a follow up interview with the Regional Maintenance Director at 10:08 AM on 3/26/2026 he stated that the ceiling light cover was replaced and that he had to order the call light panel. No additional information was provided by the facility at the time of survey exit. On 03/26/2026 at 7:11 AM, GNA #13 and GNA #18, told the surveyor that the facility never had enough washcloths to bathe residents. The surveyor observed that the supply closet contained no washcloths. The surveyor interviewed Staff #30 on 03/26/2026 8:40 AM. Staff #30 confirmed a shortage of washcloths, and stated the facility ordered 600 per month, which was never enough. The surveyor observed that the emergency linen supply did not have any washcloths. During an interview on 03/26/2026 8:53 AM, the Licensed Nursing Home Administrator stated they were aware of the linen shortage and were increasing the supply for daily use and for emergency linen.

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, interviews and record reviews, it was determined that the facility failed to follow appropriate respiratory care and services. This was found to be evident in 4 (Resident #2, 3, 8 and #11) out of 5 Residents reviewed for respiratory care.The findings include: On 03/23/2026 at 12:06 PM Resident #8 was observed in bed with an oxygen concentrator in use. The oxygen tubing was not labeled and dated and there was no oxygen in use signage on the Resident room door.At 1:02 PM on 3/23/2026 the surveyor observed Resident #2 in his/her room with an oxygen concentrator in use. There was no oxygen signage on the Resident room door. Additionally, the oxygen tubing was not labeled and dated.In an interview with staff nurse #9 at 1:10 PM on 3/23/2026 the surveyor asked what the expectation was for oxygen in use signage on Resident room doors when the Resident was using oxygen. Staff nurse #9 stated that there should be an oxygen sign on the Resident room doors and that he/she would look for oxygen signs.At 1:26 PM on 3/23/2026 the surveyor observed Resident #11 in bed with an oxygen concentrator in use. There was not an oxygen sign posted on the Resident room door/door frame and the oxygen tubing and humidifier bottle were not labeled and dated. The surveyor observed Resident #3 in his/her room with an oxygen concentrator in use at 3:04 PM on 3/23/2026. There was no oxygen signage posted on the Resident room door.In an interview with the Director of Nursing at 3:30 PM on 3/23/2026 the surveyor conveyed that there were several Residents who had oxygen in use in the facility and that there was no oxygen in use signage on the Resident room doors/doorframes. In addition, oxygen tubing and humidifier bottles were not labeled and dated. DON acknowledged surveyor.On 3/23/2026 at 4:15 PM the surveyor reviewed the facility's oxygen policy titled Oxygen Administration dated February 2026, and the policy revealed to place a No Smoking / Oxygen in Use sign on the outside of the room entrance door and in a designated place on or over the Resident's bed.Additionally, the surveyor reviewed the physician orders for Resident #2, #3, #8, and #11 on 3/24/2026 at 7:30 AM and all 4 Residents had physician orders for continuous oxygen by nasal cannula tubing, and to change tubing, mask and/or nasal cannula weekly, may change sooner as needed.No additional information was provided by the facility at the time of survey exit.

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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.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews it was determined that the facility failed to ensure the personal privacy of a Resident. This finding was found to be evident in 1 (Resident #11) out of 2 Residents reviewed for urinary catheters.The findings include:Urinary Drainage Bag collects urine from a catheter designed to be kept below bladder level to present backflow and infections. Urinary drainage bags hang on the bedframe or wheelchair.At 1:23 PM on 3/23/2026 the surveyor observed Resident #11 in bed with a yellow substance in the urinary drainage bag hanging on the bedframe. On 3/24/2026 the surveyor observed Resident #11 on a stretcher in the hall outside of room [ROOM NUMBER] with the urinary drainage bag in view.Care Plan is a personalized comprehensive roadmap addressing an individual's health, social, and functional needs. It covers activities of daily living (ADL), assessment of needs, safety modifications, health and medical care, including diagnoses. Care plan must be reviewed regularly and updated to reflect changes in health status or care needs. The care plan includes problems, goals, interventions and evaluations.The surveyor conducted a record review of Resident #11's medical record on 3/26/2026 at 7:15 AM. Review of the medical record revealed that Resident had a physician order dated 1/1/2026 for catheter bag to gravity drainage below level of bladder and catheter care every shift. Further review of the medical record revealed that Resident #11 had a care plan for a catheter with an intervention to position catheter bag and tubing below the level of the bladder with privacy bag.In an interview with the Director of Nursing (DON) at 10:30 AM on 3/26/2026 surveyor conveyed that Resident #11 had a catheter and urinary drainage bag, but there was not a privacy bag on the urinary drainage bag. The DON accompanied the surveyor to Resident #11's room where Resident was observed in bed with the urinary drainage bag hanging on the bedframe without a privacy bag. The surveyor asked the DON what the expectation was for privacy bag coverings on urinary drainage bags, and the DON stated that the urinary drainage bag should be in a blue colored privacy bag that covered the urinary drainage bag. The DON acknowledged that the urinary drainage bag for Resident #11 was not covered with the blue privacy bag.No additional information was provided by the facility at the time of survey exit.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, it was determined that the facility failed to obtain a qualifying diagnosis prior to prescribing a psychotropic medication. This was found to be evident in 1 (#97) out of 5 residents reviewed for unnecessary medications.The findings include:Psychotropic medications are used to treat mental health disorders and are considered any drug that affects behavior, mood, thoughts, or perception. There are five main types of psychotropic medications, and each type has its own specific uses, benefits, and side effects. The five main types are: antidepressants, anti-anxiety, stimulants, antipsychotics and mood stabilizers.The surveyor noted during a record review on 03/24/2026 at 11:24 AM, that a prescriber ordered, SEROquel Oral Tablet 25 MG (Quetiapine Fumarate) Give 25 mg by mouth every morning and at bedtime for Agitation -Start Date03/19/2026 1900 for Resident #97. The Director of Nursing (DON) stated Resident #97 was a new admission and the facility was trying to obtain records and learn a diagnosis for the antipsychotic medication. On 3/24/2026 at 1:30 PM the DON provided the clinical pharmacist Unnecessary Medication Review, dated 3/23/26, that stated the facility was administering antipsychotic pharmacotherapy to Resident #97 without a qualifying diagnosis. The DON stated the facility had a call out to the physician about it. On 03/26/2026 at 10:30 AM, the Psychiatric Nurse Practitioner (PNP) #25 stated he started Seroquel due to Resident #97's restlessness, yelling and delusional behaviors. PNP #25 tried the medication to see if it would help Resident #97, as the behaviors were disturbing other residents. PNP #25 stated it was too soon to give Resident #97 a diagnosis of delusional disorder since they were just admitted . The surveyor interviewed the Medical Director on 03/26/2026 10:35 AM. The Medical Director stated they were familiar with Resident #97 from before they were admitted . Resident # 97 had been having behavior issues, hallucinations and psychotic behaviors, but the prescriber should have had a diagnosis attestation before ordering Seroquel.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews it was determined that the facility failed to code Minimum Data Set (MDS) assessments accurately. This finding was found to be evident in 2 (Resident #2 and #16) out 8 Residents reviewed for accurate MDS assessments.The findings include:Minimum Data Set (MDS) assessment is a federally mandated standardized assessment tool used in Medicare/Medicaid certified nursing homes to evaluate a Resident's functional, cognitive, and physical health. It guides care planning, improves clinical accuracy, and determines reimbursement rates. Assessments occur at admission, discharge, quarterly, and upon significant changes. The MDS assessments are completed by trained staff in the nursing home.The surveyor conducted a record review of Resident #16's medical record on 3/24/2026 at 3:50 PM. Review of the 1/27/2026 Admission/Medicare-5 Day MDS assessment revealed that Resident #16 was coded No for Ostomy and Not rated for bowel continence.In an interview with the Director of Nursing (DON) at 4:15 PM on 3/24/2026 the surveyor asked the DON if Resident #16 had an ostomy, and she stated that Resident did not have an ostomy. The surveyor conveyed that the 1/27/2026 Admission/Medicare-5 Day MDS assessment for Resident #16 was coded Not rated for bowel continence. The DON stated she would review with the MDS Coordinator.In a follow up interview with the DON on 3/25/2026 at 8:07 AM, she stated that the 1/27/2026 Admission/Medicare-5 Day MDS assessment for Resident #16 was inaccurately coded for bowel continence and that the MDS Coordinator was doing a Modification of Admission/Medicare-5 Day MDS assessment dated [DATE].On 3/25/2026 at 9:25 AM the surveyor reviewed Resident #16's 1/27/2026 Modification of Admission/Medicare-5 Day MDS assessment. Review revealed that the MDS Coordinator made a correction on 3/24/2026 at 4:32 PM to the 1/27/2026 Admission/Medicare-5 Day MDS assessment which was coded Always continent for bowel continence.At 9:25 AM on 3/25/2026 the surveyor conducted a record review of Resident #2's medical record. Review of the 2/18/2026 Admission/Medicare-5 Day MDS assessment was not coded for IV Access, Central.In an interview with the Director of Nursing (DON) at 3:15 PM on 3/25/2026 the surveyor asked DON if Resident #2 had a central line and she stated that the Resident had a central line (chest port) for dialysis. The surveyor conveyed that the 2/18/2026 admission Medicare-5 Day MDS assessment was not coded that Resident #2 had a central line. The DON stated that she would follow up with the MDS Coordinator.In a follow-up interview with the Director of Nursing at 5:35 PM on 3/25/2026 she stated that the 2/18/2026 Admission/Medicare-5 Day MDS assessment for Resident #2 was inaccurately coded for IV Access, Central and that the MDS Coordinator was doing a Modification of Admission/Medicare-5 Day MDS assessment dated [DATE].On 3/26/2026 at 7:25 AM the surveyor reviewed Resident #2's 2/18/2026 Modification of Admission/Medicare-5 Day MDS assessment. Review revealed that the MDS Coordinator made a correction on 3/25/2026 at 3:24 PM to the 2/18/2026 Admission/Medicare-5 Day MDS assessment which was coded Yes for IV Access, Central.No additional information was provided by the facility at the time of survey exit.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interviews and record review, it was determined that the facility failed to ensure residents were provided with summaries of their baseline care plans. This was found to be evident for 1 (#99) out of 8 residents reviewed for care planning during the recertification survey.The findings include:During a record review on 03/24/2026 at 1:02 PM, the surveyor found no documentation that the facility obtained a baseline care plan signature or provided a copy to Resident #99 or their representative. The surveyor requested documentation from the facility. The surveyor interviewed the Director of Nursing (DON) on 03/25/2026 at 7:13 AM. The DON stated the facility lacked documentation showing that a copy of the baseline care planned was signed by, and provided to Resident #99. The social worker gave Resident #99 a copy but did not document it. The facility will work on that process.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Number of residents sampled: Number of residents cited: Based on observations, interviews and record reviews it was determined that the facility failed to develop and implement comprehensive care plans for Residents. This finding was found to be evident for 3 (Resident #2, 5 and 11) out of 8 Residents reviewed for care plans. The findings include:Hemodialysis is a life-sustaining treatment for kidney failure that filters waste, toxins, and excess fluid from the blood using a machine and a dialyzer (artificial kidney). Typically performed three times a week for 3-5 hours, it reduces symptoms of kidney failure. Blood is removed from the body through a vascular access point (fistula, graft, or catheter). Care plan is 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. The care plan includes assessment, diagnoses, goals, interventions and outcomes.During the entrance conference on 3/23/2026 at 8:45 AM with the Licensed Nursing Home Administrator (LNHA), Administrator in Training (AIT) and the Director of Nursing (DON), they stated that dialysis treatments were performed at UPMC - Regional Dialysis Center (University of Pennsylvania Medical Center) in Western Maryland.The surveyor conducted a record review of Resident #2's medical record on 3/25/2026 at 9:25 AM. Review of the medical record revealed that Resident #2 had a physician order for dialysis treatment scheduled Tuesdays, Thursdays and Saturdays. Further review of the medical record revealed that Resident #2 did not have a comprehensive care plan for hemodialysis.The surveyor reviewed the facility's policy for Care of a Resident with End-Stage Renal Disease (ESRD) dated February 2026. The policy indicated that the Resident's comprehensive care plan will reflect the Resident's needs related to ESRD/dialysis care.In an interview with the Director of Nursing and Regional Clinical Consultant at 9:45 AM on 3/25/2026 the surveyor conveyed that Resident #2 received dialysis treatments at UPMC and that review of the comprehensive care plan did not reveal a comprehensive care plan for hemodialysis. The DON acknowledged the surveyor and confirmed that Resident #2 did not have a hemodialysis care plan.At 11:20 AM on 3/25/2026 the LNHA provided the surveyor with a hemodialysis care plan for Resident #2 that was completed on 3/25/2026 by the DON, after surveyor intervention.At 1:24 PM on 3/23/2026 the surveyor observed Resident #11 in bed with 2 steri-strips to the right side of forehead. Resident #11 stated that he/she recently fell out of bed.The surveyor conducted a record review of Resident #11's medical record at 7:15 AM on 3/26/2026. Review of the progress notes revealed that Resident #11 had a fall on 3/17/2026 and sustained a laceration on the right side of forehead. Further review of the medical record revealed that there was a care plan for at-risk for falls but there was not a comprehensive care plan for actual fall. In an interview with the Director of Nursing (DON) at 10:30 AM on 3/26/2026 the surveyor conveyed that Resident #11 had a fall on 3/17/2026 with minor injury and that the Resident had a care plan for at-risk for falls but there was not a care plan for actual fall with injury. The DON stated that there should have been a care plan done for the actual fall with injury.At 3:09 PM on 3/23/2026 the surveyor observed on Resident #5's Resident room door signage which indicated that Resident was on isolation. The surveyor conducted a record review at 8:25 AM on 3/24/2026 of Resident #5's medical record and this review revealed that Resident had a physician order dated 3/19/2026 for COVID-19 isolation for 10 days. Further review of the medical record revealed that Resident #5's comprehensive care plan did not have a problem, goal or inventions for isolation and COVID-19. In an (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview with the Director of Nursing and Regional Clinical Consultant at 9:20 AM on 3/24/2026 the surveyor conveyed that the comprehensive care plan for Resident #5 did not address the isolation precautions and the COVID-19 diagnoses. DON acknowledged the surveyor and confirmed that there was not a care plan for active COVID-19 and isolation precautions.No additional information was provided by the facility at the time of exit.

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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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Lions Rehab Center	901 Seton Drive Cumberland, MD 21502

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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 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 observations, record reviews, and interviews, it was determined that the facility failed to administer medications according to professional standards procedure. This was evident for 1 (Resident #69) out of 5 residents reviewed for medication administration. The findings included: Multi-dose insulin pens are handheld devices that contain a prefilled insulin cartridge for multiple injections combined with a needle. This pen allows users to dial specific dosages. A new needle is used for each dose given and the pen is designed for single-person use. The new needle is primed before every injection to remove air bubbles and ensure the needle allows the flow of insulin. Standard priming dose is 2 units of insulin. On 3/24/26 at 8:24 AM, the surveyor observed License Practical Nurse (LPN) #4 prepare insulin for Resident #69. The surveyor watched LPN 4 place the needle onto the top of the insulin pen and then dialed the insulin pen to 20 units. LPN #4 went into Resident #69's room to give the insulin to the Resident. After returning to the medication cart the surveyor asked LPN #4 if she administered the medications. LPN #4 confirmed the she had given 20 units of Resident #69's long acting insulin (glargine) to the Resident. The surveyor asked if she was supposed to disinfect the top of the pen before placing the needle on. LPN #4 stated that she only disinfects the multi dose vials. Next the surveyor asked if she primed the needle after application before dialing in the 20 units. LPN #4 confirmed that she had not and stated that it was not part of her practice to prime the insulin needle. On 3/24/26 at 11:05 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor reviewed the observations with the DON. The DON confirmed that it was the expectation to have the inulin pen sanitized before application of the needle as well as having the needle primed to ensure accurate dosing.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interviews and record review it was determined that the facility failed to monitor a Resident's hemodialysis access site. This finding was found to be evident in 1 (Resident #2) out of 1 Resident reviewed for dialysis.The findings include:Hemodialysis is a life-sustaining treatment for kidney failure that filters waste, toxins, and excess fluid from the blood using a machine and a dialyzer (artificial kidney). Typically performed three times a week for 3-5 hours, it reduces symptoms of kidney failure. Blood is removed from the body through a vascular access point (fistula, graft, or catheter). The surveyor conducted a record review of Resident #2's medical record on 3/25/2026 at 9:25 AM. Review of the medical record revealed that Resident #2 had a physician order for dialysis treatment every Tuesday, Thursday and Saturday. Further review of the physician orders revealed that there was no order for monitoring Resident 2's hemodialysis access site (right chest port). Additionally, Resident #2 did not have a comprehensive care plan for hemodialysis and emergency management.In an interview with the Director of Nursing (DON) at 9:45 AM on 3/25/2026 the surveyor confirmed with the DON that Resident #2 received hemodialysis at an outside dialysis center 3 days a week and Resident's hemodialysis access site was a right chest port. The surveyor conveyed that Resident #2 did not have a physician order for monitoring the hemodialysis access site and a comprehensive care plan for hemodialysis. The DON acknowledged the surveyor.The surveyor reviewed the facility's policy for Care of a Resident with End-Stage Renal Disease (ESRD) dated February 2026 and Hemodialysis Access Care dated September 2010. The policy indicated that the Resident's comprehensive care plan will reflect the Resident's needs related to ESRD/dialysis care. Additionally, the policy for care of central dialysis catheters indicated that documentation in the Resident's medical record every shift should include location of catheter, condition of dressing, interventions if needed, if dialysis was done during shift, any part of report from dialysis nurse post-dialysis being given and observations post-dialysis.At 11:20 AM on 3/25/2026 the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a hemodialysis care plan for Resident #2. The care plan addressed immediate intervention for any signs/symptoms of complications from dialysis and monitoring of the hemodialysis access site (right chest port).No additional information was provided by the facility at the time of survey exit.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on record review and interview, it was determined that the facility failed to complete a resident's behavior management documentation. This was evident for 1 (Resident #22) out of 10 residents evaluated for behavioral, mental, and/or emotional health care and services during the recertification survey. The findings include: Mental disorder and psychosocial adjustment difficulty refers to the development of emotional and/or behavioral symptoms in response to an identifiable stressor(s) that has not been the resident's typical response to stressors in the past or an inability to adjust to stressors as evidenced by chronic emotional and/or behavioral symptoms. (Adapted from Diagnostic and Statistical Manual of Mental Disorders - Fifth edition. 2013, American Psychiatric Association.).On 03/26/26 at 2:00PM, the surveyor conducted a record review. Resident #22 had diagnoses of major depressive disorder and anxiety. According to the resident's medication administration record, he/she was scheduled to take Mirtazapine 7.5 mg and Magnesium Oxide 400 mg. Their care plan and treatment administration record included monitoring and documenting adverse behaviors for anti-anxiety/antipsychotic medication use. The documentation survey report included a behavior monitoring & interventions task that was left blank for the following dates and shifts: - 03/03/26- Day and evening - 03/07/26- Evening - 03/08/26- Day - 03/10/26- Evening - 03/11/26- Day and evening - 03/13/26- Day - 03/18/26- Evening - 03/19/26- Day and evening - 03/20/26- Day and evening - 03/21/26- Day and evening - 03/22/26- Evening - 03/25/26- EveningOn 03/26/2026 at 4:45 PM, the surveyor interviewed the Director of Nursing (DON) regarding the incomplete task for March 2026. The DON stated that one of the two reasons the task was incomplete was because there was a technical issue in the electronic health record or staff did not complete the task. The DON stated that she has reminded staff to complete the task every shift. On 03/26/26 at 4:46 PM, the DON acknowledged the concern.

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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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, it was determined that the facility failed to properly store food in the refrigerator. This was evident during the initial kitchen tour. This had the potential to impact food prepared in the kitchen. The findings include:On 03/23/26 at 8:51 AM, the surveyor discovered multiple containers of food that were covered with punctured foil. On 03/23/26 at 8:52 AM, the surveyor interviewed the Dietary Manager regarding food storage requirements. The Dietary Manager expressed it was an error and immediately removed the containers from the refrigerator.On 03/23/26 at 3:01 PM, the administrator acknowledged the concern.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that the facility, 1) failed to provide functioning hand sanitizers, and 2) failed to correctly identify residents requiring transmission based precautions and 3) failed to perform hand hygiene before direct contact with a resident. This was found to be evident for 5 (110, 111, 406, 407, and 409) out of 10 rooms reviewed for hand sanitizers and 1 (104) out of 7 rooms reviewed for correct transmission-based precaution signage, and 1 (Staff #18) out of 1 staff observed for hand hygiene during the recertification survey.The findings include: 1) On 03/23/2026 at 9:03 AM, the surveyor observed hand sanitizer not working in room [ROOM NUMBER], room [ROOM NUMBER] and in the hall outside the rooms 101, 111 and 112. On 03/24/2026 at 9:05 AM, the surveyor also found non working hand sanitizer in rooms [ROOM NUMBER]. When the surveyor asked Staff #7 about the process for replacing empty hand sanitizer, Staff #7 stated the facility did not yet possess the bags for the new sanitizer bottles.The Maintenance Assistant confirmed that the facility ordered the hand sanitizer. At 9:26 AM on 03/24/2026, the Administrator and Director of Nursing acknowledged the concern and stated they would investigate the issue. Airborne precautions are infection control steps taken to prevent the spread of tiny, lingering germs (like tuberculosis, measles, or chickenpox) that travel through the air. Key measures include wearing a fitted N95 respirator mask, placing the patient in a special negative-pressure room, and keeping the door closed. 2) On 03/23/2026 at 9:09 AM, the surveyor observed signage for Airborne precautions outside room [ROOM NUMBER]. This was a semi-private room and the door was open. On 03/24/2026 at 8:37 AM, the Director of Nursing acknowledged the incorrect signage being posted and stated they had already corrected it. 3) On 03/23/26 at 12:13 PM, the surveyor observed Staff #18 in the hallway transferring a dirty linen bag to a hamper, immediately followed by wheeling a resident to the activities room. Shortly thereafter, Staff #18 was observed pouring a beverage from the beverage cart. On 03/23/26 at 12:16 PM, the surveyor interviewed Staff #18. Staff #18 acknowledged that he/she did not perform hand hygiene after handling the dirty linen bag but claimed to have performed hand hygiene in the activities room before touching the beverage cart. Staff #18 further stated that most of the hand sanitizer dispensers in the 400's hallway were not functioning and/or empty. On 03/23/26 at 2:17 PM, the DON acknowledged the concerns.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview, it was determined that the facility failed to ensure that the resident's call system functioned properly. This was found to be evident for 2 residents (#32 and #100) out of 11 residents evaluated for call light access during the recertification survey. The findings include:On 03/23/2026 at 11:56 AM, Resident #100 told the surveyor, My call light is not working. GNA #13 investigated the concern and confirmed that Resident #100 and also Resident #32's call lights were not working. GNA #13 stated they would call maintenance. The Director of Nursing was in the hall and was notified of the concern. On 03/24/2026 at 7:56 AM, GNA #12 stated maintenance fixed Resident #100's call light immediately yesterday. The Maintenance Assistant stated that the call cords weren't functioning but but changing the cords fixed the issue. When the surveyor asked what backup measures the facility utilized, the Maintenance Assistant stated they gave bells to residents if they could not fix the call bell right away.On 03/24/2026 at 8:01 AM, the Administrator acknowledged the broken call light concern during an interview and stated it was repaired.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews it was determined that the facility failed to maintain a safe/functional/sanitary/comfortable environment for Residents and staff. This finding was found to be evident in 2 (Resident rooms [ROOM NUMBERS]) out of 15 Resident rooms and the Rehabilitation Department reviewed for safe, comfortable environment.The findings include:On 3/23/2026 at 11:00 AM the surveyor toured the Rehabilitation Department. The surveyor observed the screen cover to the speaker located in the ceiling to the entrance of the Rehabilitation Department. The screen cover was hanging loose from the ceiling and not intact to the ceiling. The surveyor conveyed to the Director of Rehabilitation (DOR) on 3/23/2026 at 11:05 AM that the screen cover was loose and hanging from the ceiling at the entrance of the therapy department. The DOR observed the screen cover and stated that she would notify maintenance.At 11:45 AM on 3/23/2026 the surveyor observed doors to Resident rooms [ROOM NUMBERS] that were marred, chipped and spots of splintered wood.In an interview with the Regional Maintenance Director at 9:20 AM on 3/26/2026, the surveyor conveyed that there were Resident room doors on the 300 hall with splintered wood. The Maintenance Director toured the 300 hall with the surveyor and observed the marred, chipped and splintered wood on the Resident room doors of 300 and 304. The Maintenance Director stated that he would get right on fixing these doors.In a follow-up interview with the Regional Maintenance Director at 10:08 AM on 3/26/2026 he stated that the room doors on the 300 hall were sanded. No additional information was provided by the facility at the time of survey exit.