STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215112	A. Building B. Wing	09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lorien Health Systems - Columbia	6334 Cedar Lane Columbia, MD 21044

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of a facility reported incident, medical record review and interviews, the facility staff failed to ensure outside providers obtained consent from a resident's representative to perform a debridement on a resident's wound (Resident #9). This was evident for 1 of 24 residents reviewed during a complaint survey. The findings include: Review of facility reported incident 344184 on 9/22/25 revealed 2 nurse practitioners (Staff #26 & #27) sent from Resident #9's Assisted Living entered the facility on 5/29/25 and performed a debridement on Resident #9's right heel wound without consent from the Resident's representative. Review of Resident #9's medical record on 9/22/25 revealed the Resident was admitted to the facility on [DATE] following a hospitalization with a diagnosis to include Dementia. Dementia is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life. The facility staff assessed the Resident on 4/3/25 to have a BIMS (Brief Interview for Mental Status) of 8 of 15 indicating moderate cognitive impairment. Further review of the Resident's medical record revealed the Resident was assessed by the Wound Doctor on 4/4/25 to have a right heel DTI (Deep Tissue Injury) wound. A Social Work Progress Note on 5/23/25 at 2:25 PM states spoke with Assisted Living staff who report due to patient's wounds she has to speak with regional director to see what way the patient can reentry the Assisted Living and will follow up next week. A Social Work Progress Note on 5/27/25 at 6:14 PM states scheduled with the Resident's Assisted Living staff to assess patient's wound on 5/29/25 at 9:00 AM. Interview with Resident #9's representative (RP) on 9/24/25 at 8:28 AM, the RP stated he/she was aware the Assisted Living staff were coming to assess the Resident's wound but they did not call him/her to tell him/her they were going to debride the wound and obtain consent. During interview with the Social Worker on 9/24/25 at 10:40 AM, the Social Worker stated the Resident's representative (RP) was aware the Assisted Living was sending staff to come in the facility to assess the Resident's wound and the RP was okay with that. After the incident on 5/29/25 the Social Worker stated she talked to the RP and he/she was okay with what happened and wanted the Resident to return to the Assisted Living. Interview with Staff #25 on 9/24/25 at 12:00 PM, Staff #25 stated she was the nurse for Resident #9 on 5/29/25. Staff #25 stated her Unit Manager advised her that day that she should expect a visit from someone to assess the Resident's wound for transfer back to the Assisted Living. Staff #25 stated 2 providers (Staff #26 & #27) arrived with badges and she could see their names and their credentials. Staff #25 stated she took the 2 providers to Resident #9's room and introduced them to the Resident and told the Resident they were here to assess his/her wound. Staff #25 stated she then told the 2 providers she would be in the hallway if they needed her. Staff #25 stated she then entered back in the Resident's room and saw tools on the Resident's bed and asked them weren't you just going to look and they told her they were debriding the wound. Staff #25 stated she told the 2 providers they had to stop immediately and escorted them from the Resident's room. Staff #25 stated she then called the Unit Manager and Director of Nursing who escorted the 2 providers from the facility. Interview with the Wound Doctor on 9/25/25 at 12:41 PM, the Wound Doctor stated he always obtains consent, either verbal or in writing, for wound debridement and documents that in the Resident's medical record. Interview with the Administrator on 9/26/25 at 10:10 AM confirmed the facility failed to ensure consent was obtained from the Resident's representative by outside providers for the debridement of Resident #9's right heel wound on 5/29/25.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of facility documentation and staff interview, it was determined the facility failed to provide documentation that allegations of abuse were thoroughly investigated. This was evident for 1 (#12) of 10 residents reviewed for facility reported incidents during a complaint survey. The findings include: On 9/26/25 at 11:22 AM a review of facility reported incident 344173 was conducted and revealed Resident #12 alleged to the social worker that a geriatric nursing assistant (GNA) pushed his/her head on the bed during ADL (activities of daily living) care. Review of the facility documentation revealed a written statement from Social Worker #20 who documented that during the conversation that she had with Resident #12, Resident #12 stated that he/she felt the nurses did not care about him/her. Resident #12 stated that some were rough when providing treatment and stated that one nurse made the resident cry because she was not gentle with him/her. The first nurse was Staff #18 and the second one that pushed his/her head back was Staff #17. Review of statements from 3 other residents interviewed about Staff #17 revealed they stated, I really don't like her. She just always knocks you around. She thinks she too perfect no matter what she does. She always thinks I do everything wrong. She is very good at what she does, it's just the way she does it. Another resident stated, She does not take care of me the way I want. When I say something, they treat me bad. She don't treat me good, from day one. When I see her she does not treat me well. The third resident stated, She seems to have a lot of anger at me. She unleashes a lot of anger at me. She is always telling me I am not doing things right. When I ask a question, she gets very angry at me. She says I am interfering with her work. She yells and says you always do that, you're not very patient. Further review of the investigation revealed only a written statement from Staff #18. There were no resident interviews about the care Staff #18 provided and there were no staff interviews about Staff #18. On 9/26/25 at 10:44 AM an interview was conducted with the Director of Nursing (DON) who stated that he did not have any concerns related to both Staff #17 and Staff #18. The DON stated he was not aware of what the other interviewed residents had expressed.On 9/26/25 at 12:30 PM an interview was conducted with the Nursing Home Administrator (NHA). The investigation was reviewed with the NHA, and the concern was brought up that 4 of 10 residents interviewed about care had concerns with how Staff #17 treated the residents. The NHA was asked if Staff #18 was suspended and if questions were asked about the care she provided and her demeanor. The NHA stated that she was so focused on Staff #17 that she overlooked Staff #18. The NHA agreed that she should have done more following up with the residents and more investigation related to Staff #18.

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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 medical record review and staff interview, it was determined the facility staff failed to review and revise the interdisciplinary care plans to reveal accurate interventions. This was evident for 1 (#14) of 14 residents reviewed for complaints during a complaint survey.The findings include: A 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. On 9/24/25 at 10:30 AM a review of Resident #14's medical record revealed Resident #14 was admitted to the facility in December 2024 with diagnoses that included but were not limited to cardiac arrest which resulted in anoxic brain damage, asthma, and dependence on a ventilator. Review of Resident #14's weekly skin assessment sheets documented on 12/20/24 there was a DTI (deep tissue injury) to the left heel. Weekly skin sheets from 12/20/24 to 1/24/25 documented the DTI to the left heel and on 1/24/25 there was a Stage 2 pressure ulcer to the left ischium and a DTI to the right buttock. Review of Resident #14's care plans revealed a care plan, at risk for impairment to skin integrity to the sacrum and heels related to fragile skin that was created on 12/25/24. The interventions on the care plan documented, check for incontinence every 2 hours and as needed, use barrier cream with incontinence care to prevent skin breakdown, daily skin inspection, notify the nurse of any changes to skin integrity, monitor wound characteristics during weekly wound rounds, and notify MD/NP of deteriorations or ineffective treatments, weekly skin assessment, and documented new areas per protocol and notify MD/NP as indicated. The care plan was not updated to reflect what was being done for the resident's heels. There was no documentation of elevation/float heels, heel boots, skin prep to heels, or air mattress to the bed.On 9/26/25 at 10:44 AM an interview was conducted with the Director of Nursing (DON) as he developed Resident #14's care plan. The DON stated that they should have updated the care plan with the interventions for what was being done for the heel.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on medical record review and interview, it was determined the facility failed to ensure residents received treatments per physician orders (Resident #18 and #19). This was evident for 2 of 24 residents reviewed during a complaint survey. The findings include: 1.Review of Resident #18's medical record on 9/22/25 revealed the Resident was admitted to the facility from the hospital on 7/14/24 with a diagnosis to include dermatitis. Dermatitis is a common condition that causes swelling and irritation of the skin. Review of Resident #18's July 2024 Treatment Administration Record (TAR) revealed on admission the Resident was being treated for the dermatitis by the facility staff through 7/30/24. Further review of Resident #18's medical record revealed she was seen and assessed by the Wound Doctor on 7/26/24 who diagnosed the Resident with fungal dermatitis and ordered Clotrimazole daily. Review of Resident #18's July TAR revealed the Resident received Clotrimazole until 7/30/24. The Resident was seen again on 8/2/24 and 8/9/24 by the Wound Doctor for the fungal dermatitis and stated topical agent used is Clotrimazole. The Resident was seen by the Wound Doctor on 8/16/24 who documented the fungal infection had resolved. Review of a weekly skin assessment note on 8/14/24 at 4:18 PM states rash is resolved. Review of Resident #18's July and August TAR revealed the Resident did not receive Clotrimazole from 7/31/24 through 8/14/24. Interview with the Director of Nursing on 9/23/25 at 9:25 AM confirmed the facility staff should have been administering Clotrimazole treatment to Resident #18 from 7/31/24 until 8/14/24. 2. Review of Resident #19's medical record on 9/22/25 revealed the Resident was admitted to the facility in February 2024 with cerebrovascular disease, diabetes and peripheral vascular disease (PVD). Review of Resident #19's Wound Doctor notes on 8/2/24 revealed the Wound Doctor assessed the Resident to have a right distal lateral foot wound with the cause listed as PVD. The Resident was sent to the hospital on 8/3/24 and returned on 8/9/24 with a diagnosis to include amputation of distal aspect of 5th metatarsal and diabetic right lateral foot wound. Review of Resident #19's August 2024 through September 2025 TAR (Treatment Administration Records) revealed the facility staff failed to provide treatments to the Resident's right lateral foot wound per the Wound Doctor's orders from 11/19-11/25/24, 12/21-12/23/24 and 2/8-2/12/25. Interview with the Director of Nursing on 9/29/25 at 7:51 AM confirmed the Surveyor's findings.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility staff failed to provide treatment/services to prevent/heal pressures ulcers (Resident #7, #19 & #23). This is evident for 3 of 5 residents reviewed for pressure ulcers during a complaint survey. The findings include: A pressure ulcer also known as pressure sore or decubitus ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according the their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and / or eschar in the wound bed). A deep tissue injury (DTI) is a unique form of pressure ulcer. The National Pressure Ulcer Advisory Panel defines a deep tissue injury as A pressure-related injury to subcutaneous tissues under intact skin. Initially, these lesions have the appearance of a deep bruise. The findings include: 1.Review of Resident #19's medical record on 9/22/25 revealed the Resident was admitted to the facility in February 2024 with cerebrovascular disease, diabetes and peripheral vascular disease (PVD). Further review of Resident #19's medical record revealed the Resident was transferred to the hospital on 9/13/24 and returned on 9/23/24. Review of the Resident's 9/23/24 hospital discharge summary revealed the Resident had a diagnosis to include Stage IV pressure ulcer to the sacral region. The hospital discharge instructions for the sacral pressure ulcer stated: Cleanse with soap and water, dry thoroughly, apply hydrogel, cover with bordered foam, change daily and as needed. Further review of Resident #19's medical record revealed the Resident was assessed by the Wound Doctor on 9/27/24 for his/her Stage IV Sacral Wound and the Wound Doctor changed the dressing to Plurogel, Opticell fiber dressing and bordered dressing. Review of Resident #19's September and October 2024 Treatment Administration Records revealed the facility staff failed to administer daily sacral wound treatments to Resident #19 from 9/23/24 until 10/4/24. Interview with the Director of Nursing on 9/29/25 at 7:51 AM confirmed there is no evidence the facility staff administered Resident #19's sacral wound treatments from 9/23/24 until 10/4/24. 2. On 9/22/25 at 9:38 AM a review of complaint 2614833 alleged that Resident #7 was admitted to the facility with a bedsore on [his/her] buttocks. The complaint alleged that the bedsore did not receive adequate treatment and got worse. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #7's medical record revealed the resident was admitted to the facility on [DATE]. An 8/13/25 Nurse Practitioner (NP) initial visit note documented the resident had chronic medical conditions that included cerebral palsy, diabetes, and hypertension. The note documented the resident had a fall at home in June and presented to the hospital on 8/3/25 where he/she was diagnosed with a right femur fracture. The orthopedic surgeon canceled the surgery due to high-risk infection given the resident's wounds. Review of an 8/14/25 physician note documented that while Resident #7 was home prior to hospitalization, the resident remained bedbound and was noted to have sores in the perineum, sacral area, and blisters over the legs and feet. The note documented that the resident was transferred to the facility for rehabilitation and wound care. The physician documented that the resident had a pressure ulcer of sacral region that was unstageable, and the sacral/coccyx area had black eschar. Black eschar is a dark, dry, crusty lesion that forms over a full thickness wound and is a sign of dead tissue. The resident was also noted with type 2 diabetes mellitus with a foot ulcer, a healing stage 2 ulcer on the dorsum of the right foot. Review of an 8/15/25 weekly skin team note documented that the sacrum pressure ulcer was a Stage 4 and had extended to the right and left buttock. The treatment was cleanse with normal saline solution and apply Santyl and calcium alginate, betadine to peri-wound. Review of an 8/22/25 weekly skin team note documented to cleanse the wound with NSS and apply Bactroban, Santyl, and calcium alginate betadine to peri-wound. On 8/22/25 at 10:18 PM a note documented the dressing order with the comment, patient states it was already done 2x today. Review of Resident #7's August 2025 Treatment Administration Record (TAR) documented the sacral wound was cleansed with NSS, Bactroban then Santyl and calcium alginate and betadine. The treatments were done to the wound 3 times a day. The order was for once a day. On 9/22/25 at 11:00 AM the Director of Nursing (DON) was asked about the Santyl order every shift versus every day. The DON stated that sometimes orders come over from the hospital that are not cancelled out of the system. On 9/22/25 at 11:43 AM the DON and the Nursing Home Administrator (NHA) came in and reviewed the August 2025 TAR with the surveyor. The DON stated it was something with the way the order was put into the electronic medical record. The DON stated that the treatment should have been one time a day, not 3 times a day. The concern was brought up of whether the treatment was done 3 times a day, or whether it was signed off as done 3 times a day but only done once per day. On 9/22/25 at 1:14 PM an interview was conducted with Staff #22. Staff #22 stated that the treatment pops up on the Emar and I will complete it. I would cleanse first and then apply in the order that it says. The doctor comes in every Friday, and we follow their guidance. Him and the wound team look at the wound and provide us with orders. If the order is in the eMAR then we do it. We sign it off when we do it. If it is my signature on it then I did it. If it is RF that means the patient refused it and it was not done. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/22/25 at 1:38 PM an interview was conducted with Staff #23 who stated, I would not question the order. I follow what is on the TAR because the wound doctor has a reason for his orders. It there are initials and a check mark that means it was done. On 9/22/25 at 1:57 PM an interview was conducted with Staff #24 who stated, I follow the MAR and TAR. So, if it pops up on my shift that it needs to be done, I do it and do it by the way the order says. On 9/22/25 at 2:08 PM the DON stated, the order should have been for every day, not every shift. On 9/26/25 at 12:30 PM an interview was conducted with the wound care physician, Staff #21 who stated, the order was for once a day and prn (when necessary) if the dressing comes off. Just once a day. The intent was not for 3 times a day. It is intended to be done once a day and if the dressing falls off. It doesn't change the outcome of the wound. Santyl is a special kind of dressing and doing it 3 times of day has no value and is overkill. The intention was for once a day. 3. On 9/29/25 at 8:06 AM a review of Resident #'23s medical record revealed the resident was admitted to the facility on [DATE] from an acute care facility for subacute rehabilitation as well as management of chronic health conditions. Review of weekly skin team notes documented a 7/31/25 note that revealed 5 areas on the skin that required treatment for trauma injuries and a right and left heel DTI (deep tissue injury). An 8/15/25 weekly skin team note documented the right and left heel DTI treatment as betadine LOTA (leave open to air). An 8/22/25 weekly skin team note documented the right heel treatment as betadine LOTA and the left heel treatment as calcium alginate and wrap with Kerlix. Review of Resident #23's August 2025 Treatment Administration Record (TAR) documented the treatment that was being done was, Xeroform Petrolatum Dressing Pad, apply to left heel topically in the morning for wound care. Cleanse wound to left heel with NSS (normal saline solution), pat dry, apply xeroform and dry gauze, wrap with kerlix and secure with tape daily. This treatment was done from 8/14/25 to 8/29/29. This treatment did not match what the wound physician had wanted, which was betaine to the left heel and leave open to air until 8/22/25. The treatment was then changed to calcium alginate. The calcium alginate was not initiated until 8/29/25. Further review documented, Skin Prep Wipes Miscellaneous (Ostomy Supplies) Apply to RIGHT HEEL topically every day and evening shift for WOUND CARE apply to right heel every day and evening shift for protection. Start date 7/19/25 to d/c date 9/5/25. Betadine was never applied to the right heel per the wound care physician. The skin prep wipes was the only treatment to the right heel. On 9/29/25 at 1:10 PM the treatments were reviewed with the Director of Nursing (DON). The DON stated that there appeared to be a problem on that unit. He can't believe the nurses are not following the wound care orders.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview it was determined the facility failed to keep a resident's drug regimen free from unnecessary drugs by failing to follow physician ordered parameters when administering blood pressure and diabetic medications. This was evident for 3 (#16, #17, #23) of 24 residents reviewed during a complaint survey. The findings include: 1.On 9/25/25 at 12:26 PM Resident #16's medical record was reviewed and revealed Resident #16 was admitted to the facility on [DATE] from an acute care facility for rehabilitation. Resident #16's diagnoses included but were not limited to encephalopathy, nonrheumatic aortic valve stenosis, atrial fibrillation, type 2 diabetes mellitus with diabetic peripheral angiopathy, heart failure, and end stage renal disease. Review of Resident #16's January 2025 physician's orders revealed the medication Carvedilol 6.25 mg. to be given twice per day for hypertension (high blood pressure). Carvedilol is a beta-blocker used to treat cardiovascular conditions like high blood pressure and heart failure. The physician's order stated to hold the medication for a SBP (systolic blood pressure which is the top number in the blood pressure) less than 110 or HR (heart rate) less than 60. Review of Resident #16's January 2025 Medication Administration Record (MAR) revealed in the evening on 1/12/25 the heart rate was 53. The medication was given as evidenced by the nurse's initials and a check mark in the box. On 1/13/25 in the evening the heart rate was 58 and in the evening of 1/15/25 the heart rate was 59. The medication was given both evenings. The medication was given when it was outside of physician ordered parameters. There were no notes in the medical record that indicated the nurse called the physician and received an order to administer the medications. Further review of Resident #16's physician's orders revealed the order Novolog Flex Pen with sliding scale for diabetes to be administered when the blood sugar was elevated. On 1/10/25 at 6:30 AM the blood sugar was 126. According to the sliding scale, if the blood sugar was between 100 and 199, 1 unit of insulin was to be administered. Review of the January 2025 MAR documented on 1/10/25 at 6:30 AM that the insulin was held as evidenced by a 9 which indicated a nursing note. On 1/10/25 at 6:30 AM the FS was 126, which would need 1 unit of insulin. In the box were the nurse's initials with a 9 which indicated not given, see nurses note. Review of the nurse's note documented, no coverage, 126.On 9/26/25 at 10:57 AM Resident #16's MAR was reviewed with the Director of Nursing (DON). The DON confirmed the findings. 2. On 9/25/25 at 1:00 PM a review of Resident #17's medical record was conducted and revealed the resident was admitted to the facility in October 2024 with diagnoses that included but were not limited to an extensive subarachnoid hemorrhage and right frontal intraparenchymal hemorrhage, hypertension, cerebral aneurysm, seizure disorder, and chronic hypoxic respiratory failure.Review of Resident #17's November 2024 physician's orders revealed the medication Propranolol 10 mg. to be given 2 times a day for neurostorming, and the medication was to be held if the systolic blood pressure was less than 110 and/or the heart rate was less than 55. Neurostorming is a sudden and severe episode of autonomic nervous system dysfunction that can occur after a severe brain injury. Review of Resident #17's November 2024 MAR documented on 11/27/24 in the morning the medication was given with a blood pressure of 103/61. The medication should have been held per physician's orders.On 9/29/25 at 1:10 PM the November 2024 MAR was reviewed with the DON. The DON stated that there appeared to be a problem on that unit. The DON stated, I can't believe the nurses are doing that. 3. On 9/29/25 at 8:06 AM a review of Resident #23's medical record revealed the resident was admitted to the facility in July 2025 with diagnoses that included but were not limited to hypertension, atrial fibrillation, and acute kidney failure.Review of Resident #23's September 2025 physician's orders documented the resident was to receive Hydralazine 25 mg. every 8 hours for hypertension. The medication was to be held if the systolic blood pressure was less than 110. The medication Metoprolol 50 mg. (2) tablets was to be given every 12 hours for atrial fibrillation. The medication was to be held if the systolic blood pressure was less than 110 or the heart rate was less than 60.Review of Resident #23's September 2025 MAR documented the blood pressure was 110/60. The medication was held at midnight. There was a corresponding nurses note that documented the medication was held. The medication was to be given according to the physician ordered parameters.Further review of the September 2025 MAR documented on 9/24/25 at 9 PM the blood pressure was 106/44. The medication was administered when it was outside of physician ordered parameters. The medication should have been held.A 9/15/25 physician's note documented that Resident #23's blood pressures are not well controlled. Start hydralazine 25 mg by mouth every 8 hours, hold for systolic blood pressure below. Continue Norvasc 10 mg