STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215335	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lorien Health Systems MT Airy	705 Midway Avenue Mount Airy, MD 21771

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. 20960 Based on interview, record review, document review, and facility policy review, the facility failed to protect the residents' rights to be free from verbal abuse perpetrated by staff. This deficient practice affected 2 (Resident #3 and Resident #5) of 18 sampled residents. Findings included: A facility policy titled, Abuse Policy, revised 02/06/2025, indicated, It is the policy of [facility name] to: Maintain a ZERO tolerance of ANY form of abuse or neglect of a resident. The policy specified, Verbal Abuse - The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend or disability. 1. An Admission Record indicated the facility admitted Resident #3 on 05/12/2022. According to the Admission Record, the resident had a medical history that included diagnoses of pulmonary embolism, cognitive communication deficit, hypertension, and history of falling. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/08/2023, indicated Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The facility investigation revealed Staff #25, a registered nurse (RN) unit manager (UM) met with the resident who reported that Staff #110, told them [expletive word] off, just [expletive word] off when they requested assistance. Per the investigation, the resident reported the incident took place a couple of week ago. The investigation revealed that when the resident asked Staff #110 to repeat the statement made, Staff #110 repeated the statement. The investigation indicated Staff #25 reported the incident to administration and an investigation was initiated. According to the investigation, Resident #3's roommate, Resident #14, was interviewed and confirmed that they heard the statement [expletive word] off repeated a couple of times. Resident #14 described the incident as two people that lost their temper. Resident #14 identified Staff #110 as the person who made the statement. According to Resident #14, Resident #3 always tried to joke with the staff and made inappropriate comments to the staff. The investigation indicated Staff #110 refused to engage with the facility to investigate the allegation and was terminated. Per the investigation, other residents were interviewed, and no one voiced any concerns, in-service education was completed with current staff, the police were notified, and the allegation was verified by evidence collected during the investigation. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/19/2025 at 11:11 AM, Resident #3 stated they pressed their call light and when Staff #110 came in, he stated he had another person in the air and [expletive word] off. Resident #3 stated they were told Staff #110 no longer worked at the facility. Resident #3 stated they reported the incident, it was taken care of, and they were protected. Resident #3 stated they recalled speaking to the police about the incident on the date they reported it. Resident #3 stated they were not afraid of Staff #110. Resident #3 reported they have had no other issues and was treated well at the facility. In an interview on 02/19/2025 at 12:02 PM, Resident #14 stated they did not remember when the incident occurred, but they did hear a staff person curse at their roommate. Resident #14 stated they felt safe at the facility, and no one had mistreated them. According to Resident #14, the facility did not tolerate mistreatment of residents. The quarterly MDS, with an ARD of 12/12/2024, indicated Resident #14 had a BIMS score of 15, which indicated the resident had intact cognition. In an interview on 02/19/2025 at 12:35 PM, Staff #25, the RN UM stated in 02/2024, Resident #3 stated they pressed their call light for assistance and Staff #110 responded. Per Staff #25, there was an exchange of words between the resident and Staff #110, which was witnessed by Resident #3's roommate, Resident #14. Per Staff #25, Resident #14 reported they witnessed the staff be verbally abusive to Resident #3. Staff #25 stated they reported the allegation of verbal abuse to the social worker, Director of Nursing (DON) and Administrator, who started the investigation. In an interview on 02/19/2025 at 1:06 PM, the Director of Social Services stated the allegation of verbal abuse reported by Resident #3 was confirmed due to the incident being witnessed by the resident's roommate, Resident #14, and Staff #110's lack of cooperation with the investigation. In an interview on 02/19/2025 at 2:00 PM, the DON stated Resident #3 reported an exchange of words with Staff #110. According to the DON, Resident #3 stated that Staff #110 told them to [expletive word] off. The DON stated the incident was witnessed by Resident #3's roommate, Resident #14. The DON stated this was verbal abuse. Per the DON, Staff #110 would not respond or cooperate with the investigation and was reported to the board of nursing. The DON stated the facility substantiated the allegation did occur based on the fact Staff #110 did not cooperate and statements made by the resident and their roommate. 2. An Admission Record indicated the facility admitted Resident #5 on 04/06/2022. According to the Admission Record, the resident had a medical history that included diagnoses of multiple sclerosis and spinal stenosis. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/10/2024, indicated Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility investigation revealed on 04/22/2024 at 8:40 AM, Resident #5 reported to the social worker that they requested to have one of their privacy curtains in their room changed because it was too short on 04/19/2024. Per the investigation, a staff member changed the privacy curtain to the correct length later in the afternoon on 04/19/2024. According to the resident, Resident #5 reported Staff #111 came to the room later while they sat in the doorway of their room with Resident #13 and as Staff #111 walked by, he told the resident I ought to knock you out of your chair. The investigation indicated on 04/22/2024 at 9:30 AM, the Director of Nursing (DON) spoke with Resident #13, who stated they overheard the conversation between Resident #5 and Staff #111. Per Resident #13, as they sat in the doorway with Resident #5, Staff #111 commented about how the privacy curtain was done wrong and as Staff #111 left, Resident #13 heard Staff #111 say you're lucky I don't push you out of the wheelchair or you are lucky I don't get you out of that chair. Resident #13 reported they were not sure of Staff #111's exact words, but was shocked to have heard it. Per Resident #13, they told Resident #5 to report the incident to facility on 04/22/2024 if it still bothered them. According to the investigation, on 04/22/2024 at 9:00 AM, Staff #111 was interviewed by their manager and human resources and denied making any negative comment towards the resident. The investigation indicated Staff #111 was reassigned to a different location pending the outcome of the investigation. Per the investigation, the facility notified the Medical Director, Ombudsman and police, other residents who resided on the unit were interviewed and did not report any concerns. The investigation revealed the allegation reported by the resident was verified by evidence collected during the investigation and Staff #111's employment with the facility was terminated. In an interview on 02/18/2025 at 1:18 PM, Resident #13 stated Staff #111 told Resident #5, You're lucky I don't push you out of the wheelchair. Resident #13 stated they thought Staff #111 was kidding, but he was not. Resident #13 stated Staff #111 no longer worked at the facility as he was fired. According to Resident #13, no one else had done or said anything like that and the residents were treated great. Per Resident #13, the statement made by Staff #111 was not called for. An annual MDS, with an ARD of 12/06/2024, indicated Resident #13 had a BIMS score of 15, which indicated the resident had intact cognition. In an interview on 02/18/2025 at 1:24 PM, Resident #5 stated the staff were good to them and they had no complaints. Resident #5 stated their privacy curtain was too short and they requested a new one. Per Resident #5, Staff #111 came into the room after the new privacy curtain was hung, looked at it, and when he left, he stated that he was going to knock the resident out of their chair. Resident #5 there was a witness who heard what Staff #111 said. Resident #5 stated they did not report the incident right away and during the investigation, facility staff told them they should report incident immediately. Resident #5 stated the incident with Staff #111 was the only time something of that nature occurred. In an interview on 02/19/2025 at 1:06 PM, the Director of Social Services stated the facility confirmed the allegation reported by Resident #5 based on the statement made by the resident, Resident #13 and Staff #111's lack of cooperation during the investigation. In an interview on 02/19/2025 at 2:00 PM, the DON stated the allegation reported by Resident #5 was confirmed by Resident #13, who witnessed/overheard the statement made by Staff #111. The DON stated this was verbal abuse and Staff #111 was terminated. In an interview on 02/20/2025 at 12:20 PM, the Administrator the allegation reported by Resident #5 was confirmed as verbal abuse.

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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. 30428 Based on the review of a facility reported incident, record review, interview with staff and observations, it was determined that the facility failed to administer medications to residents according to facility policy and standard nursing practice for resident medication rights. This was evident for 1(Resident #8) of 3 residents reviewed related to medication administration. The findings include: According to the state nurse practice act the five main medication rights to ensure as a licensed nurse that medications are administered safely are to verify prior to administration the; right person, medication, dose, time and route. Review of the facility reported incident MD00190869 on 2/18/25 at 10:37 AM revealed a concern related to an RN, identified as staff #108, who admitted that on 4/2/23 she prepared medications for 2 different Residents, 8 and #12 at the same time. RN #108 then proceeded to the room of Resident #108 with both medicine cups, respectively labeled for each resident. According to the statement from staff #108 included in the facility investigation packet, as she left the room for Resident #8 and proceeded to the room for Resident #12, she realized that she still had the medicine for Resident #8 and that she had administered the medication for Resident #12 to Resident #8. Medical record review for Resident #8 on 2/18/25 revealed diagnosis to include diastolic congestive heart failure, presence of prosthetic heart valve, atrial fibrillation, history of cerebrovascular accident, mitral valve insufficiency and diabetes mellitus. Resident #8 was also ordered one blood pressure medication with parameters ordered to hold for a low heart rate or systolic reading below 110 mm/hg. On 4/2/23, Resident #8, had vital signs taken prior to medication administration as per protocol and physician orders. The results were 105/68, below the administration parameter, therefore, the nurse was to hold the physician ordered blood pressure medication as administering the medication would cause the blood pressure to drop lower. Resident #12, according to medical records reviewed on 2/18/25, had diagnoses to include a history of a cerebrovascular accident and venous embolisms of which s/he was ordered multiple cardiovascular/blood pressure medications and an anticoagulant for embolism prophylaxis. On 4/2/23, RN #108 administered 3 cardiovascular medications used to lower blood pressure and the anticoagulant to Resident #8 that were ordered for Resident #12. Resident #8 after notification to the physician of the medication error, was transferred to the hospital for monitoring where s/he stayed for 4 days. Staff LPN #68 and Staff RN #197 were observed for medication pass and interviewed on 2/19/25. They both stated that 'no' you do not prepare more than one resident medication at a time, and it was not observed in progress or occurring during the complaint survey. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility policy on 'Administration of Drugs' #5: Identification of Resident must be made prior to administration of medication to the resident, and this was not completed by LPN #108 on 4/2/23. There was no date on the policy, and this was reviewed with the facility DON on exit 2/20/25. The findings and concerns were reviewed with the facility DON and NHA throughout the survey and again during exit on 2/20/25. Cross reference F760

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 30428 Based on the review of a complaint, medical records, facility policy and procedures and interview with staff, it was determined that the facility failed to have processes in place to ensure for the daily care and potential complications of residents' percutaneous endoscopic gastrostomy tubes (PEG inserting a feeding tube directly into the stomach through the abdominal wall). This was evident during the review of 5 (Residents #4, #6, #16, #17, #18) of 6 residents with PEG tubes secondary to a complaint during a complaint survey. The findings include: Review of the complaint #MD00203009 on 2/18/25 at 12:53 revealed concerns related to the care of and replacement of a PEG tube for Resident #6 after it inadvertently came out. After the replacement of Resident #6's PEG tube on 2/3/24, the complainant reported that according to the hospital, there was too much water in the balloon and that s/he was vomiting repeatedly, that's why the family requested the x-ray. Further review currently revealed diagnosis of Resident #6 including admission post anoxic brain injury (a condition where the brain is deprived of oxygen for a prolonged period, leading to damage or death of brain cells), dysphagia (difficulty swallowing-unable) and gastrostomy status. According to the complaint, on 2/3/24 Resident #6's PEG tube came dislodged and was replaced by staff RN #54 with a 20 French PEG tube and inflated with a 15ml balloon as per the SBAR (situation, background, assessment, recommendation) form completed on 2/3/24 at 11:50 AM. The on-call physician was notified prior to the replacement of the PEG tube and again after. Staff #54 requested an x-ray to confirm placement of the PEG tube at the family request as documented in the progress notes. RN #54 was interviewed on 2/19/25 at 3:10 PM. She recalled the occurrence and replaced the PEG tube in Resident #6. When asked how to determine when a PEG tube can be replaced, she stated that it should be in the physician orders along with the size of the PEG tube additionally it will state it on the PEG tube package. Regarding the tube placement with Resident #6, she stated that to check placement she aspirated and pushed air in and auscultated to confirmed placement, additionally with another nurse confirmed placement all as per the facility policy. The facility policy was reviewed at this time. There was no date on the Gastrostomy and Jejunostomy Tubes policy. According to the policy, there was nothing regarding the need for an x-ray to confirm placement. The DON was notified of the concern that the Gastrostomy policy had no date on 2/20/25 Interview with LPN #68 on 2/19/25 at 8:27 AM regarding the care of and replacement of a PEG tube. She stated that there are orders in the computer for each resident regarding what to do. Further she stated that you need physician orders to replace the PEG tube. Additionally, the PEG package tells you how much water to put in the balloon. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview completed on 2/19/25 at 8:49 AM with RN #107 revealed the same process as RN 54 and LPN #68, that you need a physician order that should already be in the system for residents that reside in the facility with PEG tubes. She further stated that getting x-rays are up to the physician, placement is checked by aspiration and auscultation. Review of the medical record for Resident #6 on 2/20/25 at 9:55 AM failed to reveal any orders for the size of residents PEG tube or directions for placement and monitoring, except for the order that was called in on 2/3/24 when the tube inadvertently came out. Review on 2/20/25 at 10:15 AM for Residents #16, #17 and #18 all who rely on PEG tubes for nutrition and medication administration all had no orders for PEG tube replacement and monitoring. Resident #4 had 2 orders in place noting 2 different sizes of PEG tubes in place. These concerns were reviewed with the facility DON on 2/19/25 at 10:25 AM. The concern for the inconsistency with lack of treatment orders and interventions for potential complications and documentation of the size of the PEG tube and balloon were reviewed throughout the survey and again during exit on 2/20/25.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 30428 Based on the review of a facility reported incident, record review, interview with staff and observations, it was determined that the facility failed to administer medications to residents without any significant medication errors. This was evident for 1(Resident #8) of 3 residents reviewed related to medication administration. The findings include: Review of the facility reported incident MD00190869 on 2/18/25 at 10:37 AM revealed a concern related to an RN, identified as staff #108, who admitted that on 4/2/23 she prepared medications for 2 different residents, #8 and #12 at the same time. RN #108 then proceeded to the room of Resident #8 with both medicine cups, respectively labeled for each resident. According to the statement from staff #108 included in the facility investigation packet, as she left the room for Resident #8 and proceeded to the room for Resident #12, it was then she realized that she still had the medicine for Resident #8 and that she had administered the medication for Resident #12 to Resident #8. Medical record review for Resident #8 revealed diagnosis to include diastolic congestive heart failure, presence of prosthetic heart valve, atrial fibrillation, history of cerebrovascular accident (a sudden interruption of blood flow to the brain), mitral valve insufficiency and diabetes mellitus. Resident #8 was also ordered one blood pressure medication with parameters ordered to hold for a low heart rate or systolic reading below 110 mm/hg. On 4/2/23, Resident #8, had vital signs taken prior to medication administration as per protocol and physician orders. The results were 105/68, below the administration parameter, so the nurse was to hold the blood pressure lowering medication. Resident #12, according to medical records reviewed on 2/18/25, had diagnoses to include a history of a cerebrovascular accident and venous embolisms. Resident #12 also ordered multiple cardiovascular medications and an anticoagulant. On 4/2/23, RN #108 administered 3 blood pressure lowering medications to Resident #8 who, it was already determined should not receive any, in addition Resident #8 received Resident #12's ordered anticoagulant (blood thinner, when not ordered can lead to a serious risk of bleeding, which can be dangerous and even life-threatening). Resident #8 after notification to the physician of the medication error, was transferred to the hospital for monitoring where s/he stayed for 4 days. While in the hospital Resident #8 was documented as having repeated episodes of tachycardia (fast heartbeat over 100) and bradycardia (heart rate below 60) with recommendations for the placement of a pacemaker (implantable medical device that helps regulate the heart's rhythm by sending electrical impulses to the heart muscle), though the family declined secondary to the resident's age. Staff LPN #68 and Staff RN #107 were observed for medication pass and interviewed on 2/19/25. They both stated that 'no' you do not prepare more than one resident medication at a time, and it was not observed in progress or occurring during the complaint survey. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The findings and concerns were reviewed with the facility DON and NHA throughout the survey and again during exit on 2/20/25. cross reference F658