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	05/07/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 4 (#9, #1, #4, #3) of 12 residents reviewed during a complaint survey.The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident.1) On 5/5/26 at 9:03 AM a review of Resident #9's medical record was conducted and revealed Resident #9 had current diagnoses of thrombocytopenia and history of malignant neoplasm of other sites of lip, oral cavity, and pharynx.Review of a 12/19/25 physician's note documented, thrombocytopenia, unspecified*: Critically low platelet count at 30 trending down from 116 on 12/14/25. The physician recommended a hospital transfer to rule out internal bleeding. Additionally, the physician documented, nystatin 100,000 unit/mL suspension, give 5 ml by mouth four times a day for carcinoma of buccal mucosa for 1 week swish for 4-5 min and spit.Review of Resident #9's MDS assessments with assessment reference dates (ARD) of 12/19/25 and 1/8/26, Section I Active Diagnoses, failed to capture the cancer and thrombocytopenia.On 5/6/26 at 2:18 PM MDS Coordinator #11 was interviewed and reviewed the MDS assessments with the surveyor. MDS Coordinator #11 confirmed the errors.On 5/7/26 at 9:16 AM the DON confirmed the errors.2) On 5/5/26 at 10:14 AM a review of Resident #1's medical record was conducted and revealed Resident #1 had a history of neuropathy and was prescribed Gabapentin (anti-convulsant) 300 mg. 2 times a day for neuropathy.Review of Resident #1's July 2025 and August 2025 Medication Administration Records (MAR) documented that Resident #1 was receiving Gabapentin 300 mg. every morning and every evening.Review of Resident #1's MDS Assessments with ARDs of 7/16/25 and 8/26/25, Section N0415, high risk drugs, failed to capture Gabapentin as an anticonvulsant.On 5/6/26 at 2:16 PM MDS Coordinator #11 was interviewed and reviewed the MDS assessments with the surveyor. MDS Coordinator #11 confirmed the errors.On 5/7/26 at 9:16 AM the DON confirmed the errors.3) On 5/5/26 at 1:24 PM a review of Resident #4's medical record was conducted and revealed Resident #4 had a history of multiple sclerosis, major depressive disorder, other specified mental disorders, and intervertebral disc degeneration, lumbar region with discogenic back pain.Review of Resident #4's October 2025 Medication Administration Record (MAR) documented that Resident #4 received Diazepam 2 mg.(anti-anxiety) twice per day and Gabapentin (anti-convulsant) 300 mg. every 8 hours.Review of Resident #4's MDS assessment with an ARD of 10/9/25, Section N0415 High Risk Medications failed to capture the anti-anxiety and anti-convulsant medications.Review of Resident #4's January 2026 MAR and April 2026 MAR documented that Resident #4 continued to receive the Diazepam 2 mg. twice per day and the Gabapentin 300 mg. every 8 hours.Review of the MDS assessment with an ARD of 1/9/26 and 4/10/26, Section N0415 High Risk Medications, failed to capture the anti-anxiety and anti-convulsant medications. Additionally, on both of the MDS assessments, antidepressant was coded as being administered. However, review of the January 2026 and April 2026 MARs failed to have documented that antidepressant medications were (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered.On 5/6/26 at 2:20 PM MDS Coordinator #11 was interviewed and stated that she did not realize she should have coded Diazepam as an anti-anxiety medication.On 5/7/26 at 9:16 AM the DON confirmed the errors.4) On 5/6/26 at 7:45 AM a review of Resident #3's medical record was conducted and revealed Resident #3 had a history that included cerebral infarction, unspecified convulsions, epilepsy, cervicalgia, connective tissue and disc stenosis of intervertebral foramina of cervical region, and obstructive sleep apnea.Review of Resident #3's November and December 2025 MARs documented that Resident #3 received Divalproex Sodium (anticonvulsant) 125 mg. every morning, Divalproex Sodium 250 mg. every evening, and Gabapentin (anticonvulsant) 400 mg. 3 times a day.Review of Resident #3's November 2025 Treatment Administration Record (TAR) documented that Resident #3 used non-invasive mechanical ventilator, BiPAP, every evening.Review of Resident #3's MDS assessment with an ARD of 11/7/25, Section N0415 High Risk Medications, failed to capture the administration of anticonvulsant medication. Review of Section O, Special Treatments, Procedures, and Programs, O0110G2, BiPAP, failed to capture the use of BiPAP every evening for obstructive sleep apnea.Review of Resident #3's MDS assessment with an ARD of 12/21/25, Section N0415 High Risk Medications, failed to capture the administration of anticonvulsant medication.On 5/6/26 at 2:12 PM, MDS Coordinator #11reviewed the MDS assessments with the surveyor and confirmed the errors.On 5/7/26 at 9:16 AM the DON confirmed the errors.

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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, the facility staff failed to follow wound care provider's orders for a resident. This was evident for 1 (Resident #8) of 3 residents reviewed for wound care during a complaint survey.The findings include:Review of Resident #8's medical record on 5/5/26 revealed the Resident was admitted to the facility in 2025 with a diagnosis to include peripheral vascular disease (PVD). PVD is a slow and progressive circulation disorder characterized by narrowing, blockage or spasms in blood vessels, commonly affecting the legs.Further review of Resident #8's medical record revealed on 2/22/26 the facility staff assessed the Resident to have a wound to the second right toe and began treatment.The Resident was seen and assessed by the Wound Care NP (Nurse Practitioner) on 2/24/26 who ordered treatment of the wound.On 3/3/26 the Resident was seen and assessed by the Wound Care NP. At that time the Wound Care NP changed the treatment orders for the Resident's second right toe. The Wound Care NP ordered: a) Cleanse wound with wound cleanser b) Apply Skin Prep at peri wound area and c) Secure dressing daily. Review of Resident #8's March 2026 Medication and Treatment Administration Records revealed the facility staff failed to administer treatment to the Resident's right second toe wound from 3/3/26 through 3/7/26, 5 days.Interview with the Director of Nursing on 5/6/26 at 9:15 AM confirmed the facility staff failed to provide wound treatment for Resident #8 from 3/3/26 through 3/7/26 for the Resident's right second toe wound.