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	08/13/2025

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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined the facility failed to provide documentation that Advance Directives (AD) was reviewed with and/or information/education regarding advance directives provided to residents and/or their responsible representatives (RP). This was evident for 2 (#4 and #11) of 37 residents reviewed during a recertification/complaint survey. The findings include:1) On [DATE] at 2:35 PM, a review of the Resident’s #11’s medical record revealed that there was no documentation to support that the advance directives were obtained as required. On [DATE] at 11:37 AM A review of the resident records revealed that a Social Work admission Assessment was completed on [DATE]; section “F” of the assessment revealed that Resident #11 had a MOLST form in the chart. However, there was no evidence to support that the AD was obtained, or that documentation was provided to the resident and or the representative. On [DATE] at approximately 11:49 AM, in an interview with the Director of Nursing (DON), she was asked for Resident #11’s AD, and she stated that they would investigate further. On [DATE] at 12:40 PM, the surveyor followed up on the AD documentation request and it was revealed that a Power of Attorney (POA) document was obtained from the resident’s representative after the surveyor’s inquiry. However, there was still no documentation to support that the advance directive information was provided to the residents or their representative(s) as required. The DON verbally confirmed and acknowledged that the AD documentation was not available. On [DATE] at 3:12 PM, in an interview with the social work director, she reported that she spoke with the family about the advance directives and they stated that they will have to look to see if they have the resident’s AD in their possession. 2) On [DATE] at 2:03 PM a review of Resident #4's medical records revealed a Maryland Order for Life Sustaining Treatment (MOLST) dated [DATE] which indicated “No CPR, Option B, Palliative and Supportive Care” selected. There was no Advance Directives (AD) found in the resident's records. However, further review of the medical records failed to reveal documentation of advance directives or that a discussion about advance directives had occurred with the resident and/or their RP. On [DATE] at 2:19 PM a review of social services progress notes did not reveal any documentation on Advance Directives. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:02 PM, in an interview with the Director of Nursing (DON), she stated she could not find any Advance Directives in Resident #4's chart. However, DON stated that she followed up with the Social Worker (SW #3) who confirmed there was no AD in the resident’s chart. DON further stated that SW #3 was currently calling Resident #4's family. On [DATE] at 3:04 PM, surveyor reviewed the concern regarding the lack of documentation about advance directives in the medical record with the Director of Social Services (Staff #3), in the presence of the DON, Staff #3 confirmed that she did not address Advance Directives with Resident #4 and/or their RP. DON stated that they were doing an audit to make sure all the residents had AD and/or documentation that AD was reviewed and education provided to the residents and their RPs. [DATE] 12:22 PM Review of the facility's Advance Directives/Advance Care Planning policy statement and Procedure noted that 1. Prior to, or upon admission, the admission staff and/or Medical Provider will ask resident's and/or their family members about the existence of any advance directives including the Maryland MOLST form. 2. Should the resident indicate that he or she has issued advance directives about his or her care and treatment, the facility will require that copies of such directives be included in the medical record . The facility staff failed to provide evidence that this was done for Resident #4.

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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. Based on record review and interviews, it was determined that the facility failed to develop a comprehensive person-centered care plan. This is evident for 1 (Resident #11) of 24 resident care plans reviewed during the survey process.The findings Included:A voiding trial is the removal of a urinary catheter allowing the bladder to fill with urine naturally, and monitoring voiding to see if the bladder has returned to normal so that the urinary catheter can be removed permanently.On 08/04/2025 at 2:21 PM, in a resident representative interview, they expressed concern for the Resident #11's recurrent Urinary Tract Infection (UTI).On 08/11/2025 at 1:11 PM, in an interview with RN #10, she reported that Resident #11 had a history of recurrent UTI. The resident was admitted to the facility without a urinary catheter; however, after the resident's admission, the resident began to have difficulty with urination, as a result a urinary catheter was ordered and inserted as ordered. RN #10 reported that they have attempted voiding trials since the resident's admission, but the resident failed them, as a result the resident still had a urinary catheter. She reports that Resident#11's goal is to be discharge home.A review of Resident #11 charts revealed that medication order for Flomax Capsule 0.4 MG, one capsule by mouth at bedtime for urinary retention. On 7/14/2025 urinary catheter was ordered for urinary retention. On 7/28/2025 a urology consults for Urinary retention and chronic UTI's was ordered.On 08/11/2025 at 1:57 PM, a review of Resident #11's care plan revealed that there was no documented evidence to support that the facility developed a person-centered care plan to address urinary retention and urinary catheter usage.On 8/11/2025 at approximately 3:00 PM, in an interview with the unit manager (Staff #5), she explained that care plans are usually done frequently, whenever there is a change in condition, quarterly or a decline in resident status. She was asked if Resident #11's care plan should be updated to reflect the interventions that were implemented such as the voiding trials, and she stated that she will update the care plan with the dates of the voiding trials.8/11/2025 at approximately 3:30 PM, the Director Of Nursing (DON) was notified that the surveyor had concerns that the urinary catheter was initiated in the facility on 7/14/2025 for urinary retention; however, there was no documented evidence to suggest that Resident #11's care plan was developed to address the care needs of urinary retention and urinary catheter care. She acknowledged that it was not developed until 8/11/2025.

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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 record review and interviews, it was determined that the facility failed to revise the care plan by the interdisciplinary team after each assessment. This was true for 1 (Resident #21) of 3 resident records reviewed for hospitalization during the recertification/complaint survey.The findings include:A care plan is a tool used to summarize the resident's healthcare needs, treatments, and care goals. This tool is to be developed within 7 days after completion of the comprehensive assessment (MDS) and prepared by an interdisciplinary team.The Minimum Data Set (MDS) is a standardized comprehensive assessment tool that measures health status in nursing home residents.Mechanical ventilator is a machine that promotes or supports the movement of air in and out of the lungs. The machine takes over the work of breathing when a person is unable to breathe on their own.Tracheostomy is a surgical hole or stoma which consists of making an incision on the front of the neck to open a direct airway to the trachea. A tracheostomy allows air to pass into the windpipe to help with breathing.On 08/05/2025 at 12:03 PM, in an interview with Resident #21, the resident stated that he/she was sent to the hospital in mid-July 2025 for respiratory distress.On 08/12/2025 at 4:08 PM, a review of the resident's emergency room treatment record indicates that the resident was dependent on a mechanical ventilator via a tracheostomy and resident was sent to the hospital after being found unresponsive and without a pulse in the facility, mid-July, the resident was subsequently resuscitated and sent to the hospital.On 08/13/2025 at 8:45 AM, a review of Resident #21's MDS revealed that an assessment was completed on 7/21/2025 post hospitalization. However, there was no documented evidence to support that the facility reviewed and revised the care plan for continuous mechanical ventilation related to respiratory insufficiency after each MDS assessment.On 8/13/2025 at approximately 11:15 AM, the Director of Nursing was notified that Resident #21's respiratory care plan was not reviewed and revised after the last assessment following the mid-July 2025 hospitalization. She verbally acknowledged the care plan should be reviewed as required.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on Observation, record reviews and staff interviews, it was determined that the facility failed to label and date humidifier bottles and oxygen tubing with change dates per physician's orders. This was evident for 2 (#33 and #47) of 4 residents reviewed for Respiratory care during the recertification/complaint survey.The findings include:During the initial rounds on 8/4/25 at 10:16 AM and on 8/5/25 at 8: 56 AM, Resident #33 was observed to be on supplemental oxygen (O2) delivered through a nasal cannula (a device that delivers O2 through the nose) and attached to a humidifier bottle on the O2 concentrator at the bedside in the resident's room. The humidifier bottle and the O2 tubing were not dated to indicate when they were last changed. A review of the physician's order on 8/5/25 at 9:10AM revealed an order that reads Check SPO2 Q shift - Administer OXYGEN TO MAINTAIN SPO2 >92% DOCUMENT LITERS PER MINUTE (LPM) VIA NASAL CANNULA APPLICABLE FOR HYPOXIA . A second order reads: OXYGEN EQUIPMENT: 11-7 Shift Weekly O2/NEB Equipment CHANGE O2 TUBING NASAL CANNULA AND HUMIDIFER BOTTLE WEEKLY IF IN USE - LABEL TUBING WITH DATE CHANGED. The order was dated 12/12/24 every night shift every Sun EVERY 7 DAY.On 8/5/25 at 8:30 AM the surveyor went to resident #47's room and observed another O2 concentrator with humidifier bottle attached, at the bedside. An oxygen tubing was connected to the humidifier and was lying on the floor. Both the oxygen (O2) tubing and the humidifier bottle were not dated to indicate when it was last changed. A review of the physician's order for Resident #47 revealed an order dated 6/16/25. The order read, Oxygen 2 LPM via nasal cannula PRN to keep pulse ox above 92% .On 8/5/25 at 9:38 AM, Staff #6, a Licensed Practical Nurse (LPN) was shown the two rooms with the O2 tubing and humidifier bottles not labelled. She acknowledged that they were not and stated that they should have been labelled even if the orders were as needed. She explained that night shift was responsible for labelling the O2 tubing. On 8/5/25 at 9:53 AM The Director of Nursing (DON) was made aware of the concern. She stated that it was unacceptable and will check it out.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review and interviews, it was determined that the facility failed to assess the effectiveness of pain medication consistent with professional standards of practice. This was evident for 1 (Resident #2) of 5 resident records reviewed for unnecessary medications during the recertification/complaint survey.The findings included:On 08/08/2025 at 12:52 PM, a review of Resident #2's record revealed that the resident had an order for traMADol HCl Tablet 50 MG Give 0.5 tablet by mouth every 6 hours as needed for PAIN. A review of the resident's Medication Administration Record (MAR) revealed that on 6/23/2025 at 05:59 AM the resident received tramadol for a pain level of 7 out of 10 (severe pain); however, it was documented that the medication was not effective. A review of the Treatment Administration Record (TAR) and MAR for medication reassessment and interventions showed that there was no documented evidence that additional interventions were implemented.On 08/11/2025 at 1:15 PM, in an interview RN #10, she was asked about the expectation for the medication administration of as needed (PRN) medication. She explained that PRN pain medications was administered based on a pain scale. A resident reporting a pain score of 4 would be offered a Tylenol first, if available based on the physician order. If the pain score was higher she would offer the narcotics based on the physician order. Reassessment would be done within the hour after administering medication. She was asked if there were any non- pharmalogical interventions that were used to aid with pain. She stated that sometimes an ice pack may be offered as an alternate intervention. When asked if she documented this anywhere in the resident records, she stated that not really unless there was a physician's order for ice pack, in that case it would be found on the TAR. Otherwise, the intervention would be discussed during shift report with the other nurse.08/11/2025 2:40 PM, in an interview with RN #10 and the Director Of Nursing (DON), the surveyor notified them that there was no documentation to support that the above-mentioned pain medication ineffectiveness was addressed. A review of the progress notes revealed that the pain medication was given on 6/23/2025 at 05:59 AM, but additional interventions were not offered to Resident #2's until approximately 10am on 6/23/2025.The professional standard of practice for pain medication reassessment for effectiveness is 1-hour after medication administration.The DON acknowledged that based on the available documentation the pain medication reassessment was completed late.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined facility staff failed to remove expired supplies from a medication cart. This was evident for 1 of 3 medication carts reviewed for medication storage and labeling during a recertification survey.The findings include:An IV start kit typically includes essential supplies for inserting an intravenous (IV) line. They usually contain a tourniquet (used to make veins more visible and accessible for needle insertion), antiseptic wipes (used to disinfect the insertion site, minimizing the risk of infection), IV catheter (the device that is inserted into the vein to provide access for fluids or medications), a transparent dressing, gauze, tape, and sterile gloves. They may also include other items like saline syringes, IV tubing, and needles. The specific contents can vary by manufacturer and kit type.Expiration dates are primarily related to maintaining the sterility of the kit's components. Using expired items can pose infection risks.On [DATE] at 8:50 AM, Medication cart #1 on the Prospect Unit was reviewed for Medication Storage and Labeling in the presence of Registered Nurse (RN #7). Surveyor found an IV Start kit with expiration date of [DATE] in the bottom drawer of the med cart.RN #7 confirmed the IV start kit was expired and stated it should not have been in the med cart. He immediately removed the expired IV start kit and stated he was going to discard it. On [DATE] at 1:21 PM, In an interview with the Director of Nursing (DON), surveyor shared concerns regarding findings of expired IV start kit during Medication Storage and Labeling review. DON stated she was aware of the surveyor's finding and added that the expired IV start kit was immediately removed from the med cart. She further stated that the Nurses and Unit Managers were responsible for checking the med carts for expired items.On [DATE] at 1:22 PM a review of the facility's policy and Procedure for Storage of medications revealed the following: It is the policy of this facility that drugs and biologicals shall be stored in a safe, secure, and orderly manner. Under Procedure: .3) No discontinued, outdated, or deteriorated drugs or biologicals are available for use in this facility. All such drugs are destroyed

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 1 (Resident #65) of 37 residents reviewed during a recertification / complaint survey.The findings include:A closed record review of Resident #65's medical records for death conducted on [DATE] at 10:47 AM, revealed the resident was admitted to the facility on [DATE] and discharged on [DATE]. On [DATE] at 11:41 AM, review of Medication Administration Record (MAR) and Treatment Administration Record (TAR) for [DATE] revealed staff documentation that assessments were done and treatments were provided during the evening and night shifts on [DATE] for Resident #65:- Medications scheduled to be given in the evening and at bedtime for [DATE] had staff documenting NI.[NI=Clinical Finding WNL(within normal limit) - No intervention required] as indicated under Chart codes/Follow up codes.- Night shift staff documented 0 under Assess Resident daily for change of status/Assess for Delirium daily.- Night shift staff checked that resident was assessed for Bleeding/Bruising Precautions. - Night shift staff checked that resident's Oxygen: Every shift O2 @ 2 L/Min continuous via N/C for hypoxia.Maintain O2 above 93% . was monitored.- Night shift staff documented that they performed pain assessment and resident's pain score/level was 0 (No pain).Aspiration Precautions, Barrier cream to buttocks and peri area every shift after soap/water was checked including Elevate/float heels while in bed, Fall precautions, Pressure relieving device, and Turn and Repositioning every 2 hours. Resident #65 was pronounced dead at 12:30 PM on [DATE] and body released to funeral home at 16:47 (4:47 PM) on [DATE]. Hence, Resident #65 was no longer in the facility when evening and night shift staff documented they completed the above mentioned tasks.On [DATE] at 11:52 AM, a review of nurses' progress notes revealed a change in condition documentation dated [DATE] at 12:10:. Resident was sitting in dining/activity room following BINGO activity and awaiting lunch to arrive when s/he became short of breath.EMTs arrived at approx. 12:23, at which time resident was assessed and about a minute following their arrival resident ceased breathing. Resident assessed for pulse and signs of life which were confirmed to be absent. Resident with no respirations, no heart sounds, and was pronounced deceased by EMTs at 12:30pm.On [DATE] at 12:50 PM in an interview with the Director of Nursing (DON), surveyor reviewed Resident #65's MAR and TAR for [DATE]. DON verified that evening and night shift staff documented on [DATE] that ordered treatments/ assessments/monitoring were performed. She confirmed that the staff documentation was inaccurate as Resident #65 had expired and was no longer in the facility at the time of their documentation. DON stated that she was very disappointed and was going to talk to the specific nurses who documented on [DATE] after Resident #65 was deceased . DON further stated that she was going to provide staff education.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on review of facility documentation and interview, it was determined the facility staff failed to have a social service director and a medical director participate monthly in the facility's Quality Assessment Performance Improvement (QAPI) committee meetings.The findings include:Review of the monthly QAPI sign-in sheet for August 2024, the medical director signature block indicated Leave of Absence (LOA) and March 2025 and June 2025, the social service director signature block indicated Leave of Absence (LOA). During an interview on 08/13/2025 at 11:41 AM with the Director of Nursing (DON), and staff # 4, the DON stated that there is no designated person for the Medical director, and the facility had one social services worker, who is the director. Staff #4 stated that he/she would discuss the information from the QAPI meeting during the risk management meeting with the members who were absent from the QAPI committee meeting. On 08/13/2025 at 11:48 AM staff #4 stated that he/she acted as the designee for the Social Services Director and the facility had a covering medical director. When asked if staff #4 has training in social services, he/she stated no. and the sign in roster did not have a signature for the covering medical director.On 8/13/2025 at 12:03 PM the DON and Staff #4 were made aware of the concern for not having a qualified designee for the medical director and social services director in attendance for the months of their absence from the QAPI committee meetings.