STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215341	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lorien Nsg & Rehab Ctr Belair	1909 Emorton Road Bel Air, MD 21015

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on review of a facility reported incident, medical record review, and interview, it was determined that the facility failed to provide needed activities of daily living (ADL) for a resident totally dependent for care (Resident #10). This was evident for 1 of 29 residents reviewed during a complaint survey. The findings include:Review of facility reported incident 336885 on 11/14/25 for Resident #10 revealed the facility substantiated Staff #13 failed to provide care for the Resident on 5/23/25 from 3-11 PM.Review of Resident #10's medical record revealed the Resident was admitted to the facility in 2017 with a diagnosis to include Multiple Sclerosis.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.Review of the Resident #10's quarterly MDS assessment on 5/2/25 revealed the facility staff assessed the Resident in Section GG Functional Abilities to be dependent on staff for self-care. At that time the Resident was assessed in Section C to have a BIMS (Brief Interview for Mental Status) of 14 of 15, indicating he/she was cognitively intact.Review of facility investigation on 11/14/25 revealed on 5/23/25 at approximately 8:30 PM the Resident's nurse (Staff #14) stated she noted the Resident had a bowel movement and asked the Resident's GNA (geriatric nursing assistant) Staff #13 to change the Resident. In the investigation Staff #13 stated she went into the Resident's room at approximately 11 PM to empty the Resident's urinary catheter for urine and did not realize the Resident needed to be changed. Further review of the facility investigation revealed GNA #15 took over care for Resident #10 on 5/23/25 for 11 PM - 7 AM shift and stated when went into Resident #10's room and it smelled bad. GNA #15 stated Resident #10 stated the previous GNA never came in and changed him/her. Further review of Resident #10's medical record revealed the Resident was discharged from the facility in June 2025.Interview with the Administrator on 11/14/25 at 10:50 AM confirmed the facility staff failed to provide ADL care for Resident #10 on 5/23/25 3 PM- 11 PM shift.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215341	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lorien Nsg & Rehab Ctr Belair	1909 Emorton Road Bel Air, MD 21015

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 #1). This is evident for 1 of 3 residents reviewed for pressure ulcers during a complaint survey.The findings include:Review of Resident #1's medical record on 11/13/25 revealed the Resident was admitted to the facility on [DATE]. On admission the Resident was assessed to have no pressure ulcers.Further review of Resident #1's medical record revealed on 9/21/25 the Resident was assessed to have an open area on his/her left buttock, the provider was notified, treatment was started and a wound consult was ordered.On 9/25/25 the Resident was assessed by the Wound Nurse Practitioner to have a Stage III pressure ulcer to the left buttock and a DTI (deep tissue injury) to the right heel. Further review of the Wound Nurse Practitioner (WNP) notes revealed the WNP ordered for the Resident's right heel cleanse with wound cleanser, skin prep twice daily and offloading foam heel boots. The Resident was seen by WNP #2 on 10/2/25 who assessed the Resident‘s right heel DTI and ordered cleanse with wound cleanser, skin prep twice daily and offloading foam boots. The Resident was seen by WNP #1 on 10/9/25 who assessed the Resident's right heel DTI and ordered cleanse with wound cleanser, skin prep twice daily and offloading foam boots. WNP #1 also advised on obtaining an x-ray of both the left buttock and the sacrum to rule out osseous changes.Further review of Resident #1's medical record revealed the Resident was transferred to the hospital on [DATE]. Review of Resident #1's physician orders and Treatment Administration Records for September and October 2025 revealed the right heel DTI orders of cleanse with wound cleanser and skin prep twice daily were not ordered or administered from 9/25/25 through discharge on [DATE].Further review of Resident #1's medical record revealed the x-ray for the left buttock and sacrum was not completed prior to discharge on [DATE].Interview with the x-ray staff (Staff #12) on 11/17/25 at 11:12 AM, Staff #12 stated the x-ray for Resident #1 was not ordered until 10/12/25 at 7:15 PM.Interview with the Director of Nursing on 11/17/25 at 11:15 AM confirmed the facility staff failed to administer right heel treatments to Resident #1 from 9/25/25 until discharge on [DATE] and failed to obtain an x-ray per the Wound Nurse Practitioner's recommendations.