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	01/09/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview it was determined the facility failed to ensure food temperatures were taken and recorded prior to the serving of food, ensure foods were not left open to air within the walk in refrigerator and freezer, ensure the labeling of foods and follow professional standards for food service safety. This was evident during the surveyor's initial tour of the facility's kitchen and has the potential to impact all residents who eat food from the kitchen. The findings include: 1. On 01/05/2026 at 7:45 AM the surveyor conducted an initial tour of the facility's kitchen. On 01/05/2026 at 7:49 AM the surveyor observed Dietary Aide (DA) #10 assisting with the plating of food on the serving line taking a drink from a personal beverage container which they placed back onto the shelf on the food serving line equipment. Dietary Aide #10 was observed continuing to assist with the plating of food and the surveyor shared the concern with them. After the sharing of the concern by the surveyor, no action was observed to be taken in response to the personal beverage on the food serving line equipment. A bottle of drinking water was additionally observed by the surveyor sitting on the shelf of the food serving line. On 01/05/2026 at 7:49 AM the surveyor conducted an interview of DA #10 and inquired as to if they had received training in regards to personal items on the food serving line at which time DA #10 stated: Okay. On 01/05/2026 at 7:50 AM the surveyor conducted an interview of Dietary [NAME] (DC) #11 who confirmed that they were the person in charge of the kitchen at the time as the facility's Certified Dietary Manager was not there and the surveyor shared the concern with them at which time they stated regarding DA #10: S/he's new, I'll remove it now. When the surveyor inquired to DC #11 if the facility provides training to all kitchen staff regarding personal items on the serving line, they stated: Yes. DC #11 was then observed removing the personal beverage cup from the food serving line. 2. On 01/05/2026 at 7:56 AM the surveyor observed the facility's walk in refrigerator at which time various foods were observed on a mobile metal food cart open to air with no covering present: beans, two trays of a red gelatin type food, riblet portions, and chicken patties. On 01/05/2026 at 7:58 AM the surveyor requested and performed a dual observation of concerns and conducted an interview with DC #11 who observed and acknowledged the concerns and stated: I knew s/he was getting behind so I threw it in there real quick, I know, I need to put my cover on it, I put it in there real quick. After surveyor intervention on 01/05/2026 at 7:59 AM, the surveyor observed DC #11 obtain a cover and cover the cart of food. 3. On 01/05/2026 at 8:05 AM the surveyor observed the facility's walk in freezer at which time the following foods were observed left open to air and unlabeled: pepperoni, cornbread, two open bags of a circular round breaded type food, and an angel food type cake with a slice missing from it with no labeling or date present. Additionally a container of ice cream was observed with ice cream present on the top of the outside of the container's lid. 4. On 01/05/2026 at 8:07 AM the surveyor conducted an interview and inquired to DC #11 as to where the hot food temperatures were recorded/located. DC #11 was observed removing the temperature binder from a rack and showed the surveyor previous dates of temperature logs, and informed this surveyor that the temperatures were not done this morning and there was no sheet completed for today in the book. DC #11 reported: We are responsible for the temperatures, but the dietary aide is a newer employee, but we are both responsible for taking temperatures and recording (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	on the log. After surveyor intervention at this time, food temperatures were taken by DC #11. This surveyor shared the concern with DC #11 that temperatures of food had not been taken prior to food being served to Residents, and DC #11 acknowledged and confirmed understanding of the concern. On 01/05/2026 at 12:16 PM the survey team was approached unsolicited by Dietary Manager (DM) #12 who provided various kitchen logs including temperature logs to the surveyor which had not been requested. At this time the surveyor inquired to DM #12 as to why the documentation was being provided at which time DM #12 stated to the surveyor: Food temperatures were taken, but not recorded, so here they are. At this time, the surveyor shared the concern with them and informed them that after surveyor intervention, food temperatures were then taken. On 01/05/2026 at 12:30 PM all concerns were shared with the facility's Administrator and Director Of Nursing who acknowledged the concerns. On 01/07/2026 at 8:55 AM the surveyor conducted an interview of Certified Dietary Manager (CDM) #6 and shared the concerns at which time they responded: Okay, thanks for letting me know. On 01/09/2026 at 9:05 AM the surveyor rounded the kitchen and conducted an interview with CDM #6 who reported that upon hearing the surveyor's concerns from their staff, they had observed and removed the opened and unlabeled items from the cold food storage. CDM #6 acknowledged and confirmed understanding of the surveyor's concerns.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, it was determined that the facility failed to ensure a system was in place to notify the local Ombudsman of the facility's initiated transfers to the hospital. This was evident for 1 (Resident #113) out of 3 closed records reviewed during the annual survey. The findings include:Transfer and discharge: Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same facility. Specifically, transfer refers to the movement of a resident from a bed in one facility to a bed in another facility when the resident expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another facility or other location in the community, when return to the original facility is not expected.On [DATE] at 11:41AM, during a review of Resident #113's electronic medical record, the Surveyor discovered that the resident was admitted to the hospital on [DATE].On [DATE] at 1:00PM a review of the Discharge List for the facility recorded between [DATE]-[DATE] that Resident #113 was not included on the list for his/her transfer to the hospital on [DATE]. Further review of the discharge lists from October and [DATE], failed to reveal any resident transfers to the hospital and included residents who had been discharged home, to another facility, to a funeral home, or who had expired.On [DATE] at 2:07PM, the Surveyor conducted an interview with the Nursing Home Administrator (NHA) in the presence of the Director of Nursing (DON). The Surveyor was informed that Corporate Office Staff #14 was responsible for sending the residents transfer/discharge notification to the local Ombudsman weekly via email. The Surveyor expressed the concern that Resident #113's transfer to the hospital on [DATE] was not included in the Discharge Lists for the facility for the month of [DATE] and that lists only contained residents who had been discharged home, to another facility, to a funeral home, or who have expired. The NHA acknowledged the Surveyor's findings and stated that the facility had not been sending resident transfer to the hospital notification to the local Ombudsman; however, would like to confirm with Corporate Office Staff #14.On [DATE] at 8:37AM, the NHA provided the Surveyor with a list of the transfers to the hospital for the month of [DATE]. Resident #113 was on the list for transfer on [DATE]. The Surveyor compared the list of residents who were transferred to the hospital in [DATE] to the discharge lists sent to the local Ombudsman for [DATE]. The discharge list failed to include the residents who were transferred to the hospital. The NHA confirmed that Corporate Office Staff #14 does not send resident transfer notification to local Ombudsman; however, sends resident discharges out of the facility. The NHA stated that Corporate Office Staff #14 will begin to send resident transfer notifications, along with the resident discharge notifications to the local Ombudsman weekly via email.

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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. Based on observations, medical record reviews, and interviews with facility staff, it was determined that the facility failed to follow professional standards of practice by not administering physician-ordered medications at their scheduled times, and failed to ensure the timely administration of medications. This was found to be evident for 2 (Resident # 103 and Resident # 107) of 6 residents observed during medication administration observation, and for 1 (Resident #11) out of 2 Residents reviewed for pain during the survey. Findings include: 1.) Type 2 Diabetes Mellitus is a chronic condition where the body either does not produce enough insulin or doesn't use insulin effectively causing blood sugar levels to rise. A medication administration observation was conducted on 1/8/26 at 10:05 AM for Resident #103. Staff # 9, a registered nurse (RN) reviewed the computer screen as he poured medications for Resident # 103. The computer revealed a highlighted pink screen displaying the resident medication information for Aspirin Enteric Coated (EC) 81 mg tablet scheduled time of 8:00AM and medication information for Metformin 1000mg tablet displaying a scheduled time of 7:30AM. Staff # 9 administered Resident # 103's medications at 10:05 AM. Review of the physician orders for Resident #103 on 1/8/26 revealed the following: Metformin 1000mg give 1 tablet by mouth two times a day for Type 2 Diabetes before breakfast/dinner. Scheduled for 7:30AM. Metformin is an oral diabetic medication that is used to help control high blood sugar levels. Aspirin Enteric Coated (EC) 81 mg give 1 tablet by mouth 1 time a day for Cerebrovascular Accident (CVA). Scheduled for 8:00AM. Aspirin is used for preventative therapy against cardiovascular events such as heart attacks and strokes. Staff # 9 administered Resident # 103's medications outside of the scheduled physician ordered times. 2.) A medication administration observation was conducted on 1/8/26 at 10:05 AM for Resident #107. Staff # 9 reviewed the computer screen as he poured medications for Resident #107. The computer revealed a highlighted pink screen displaying the resident medication information for Baclofen 10 mg tablet scheduled time of 8:00AM and medication information for Lyrica 75mg capsule displaying a scheduled time of 8:00AM. Another nurse, Staff #8 entered Resident #107's room at this time as Staff # 9 was preparing the medications for Resident #107 and informed Staff # 9 that she would administer the resident the scheduled Lyrica 75mg capsule. At this time Staff # 8 administered Lyrica to Resident # 107 at 10:15AM. Staff # 8 stated to the surveyor and Staff # 9 that she was administering narcotics to the residents on the unit hall. Review of the physician orders for Resident #107's revealed the following: Baclofen 10 mg give 1 tablet by mouth three times a day for muscle spasm. Scheduled for 8:00AM Lyrica 75 mg give 1 capsule by mouth three times a day for moderate to severe pain. Scheduled for 8:00AM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff # 8 and Staff # 9 administered Resident # 107's medications outside of the scheduled physician order times. An interview was conducted with Staff # 9 at 10:30AM and he was asked why he administered the medications that were highlighted pink on the computer screen outside of the scheduled time range. He stated that the medications were administered late because he had to administer more than 10 other residents their medications prior and that he also had to obtain vital signs on the residents as well. Staff # 8 who was present in the hallway was interviewed at this time and she stated that she was there to assist. An interview was conducted with the DON on 1/8/26 at 2:20PM and she was made aware of the concerns identified during the medication administration observation and was asked what the expectation is for administering scheduled medications. The DON stated that during medication administration, if a pink screen displays or highlights on the computer screen, this is to alert the staff that the medication is late. She went on to say that when the pink screen is displayed, the staff are not to give the medication and are to notify the physician. The DON further stated that nurses are to notify the physician when medications are late and obtain a new order to administer the medication. She stated that education will be provided for the staff. All concerns were discussed with the Administration team at the exit conference on 1/9/26. 3.) On 01/06/2026 at 9:46 AM the surveyor conducted an observation of Resident #11 who was heard from the hallway stating: Help, I'm in pain. On 01/06/2026 at 9:48 AM the surveyor shared the concern with Licensed Practical Nurse #18 who stated: Okay. On 01/06/2026 at 9:51 AM the surveyor conducted an interview of Front Desk Staff #19 who confirmed Resident #11 was appropriately able to express needs. On 01/09/2026 at 9:29 AM the surveyor conducted an interview of Resident #11 who described experiencing delay relating to medication administration. On 01/09/2026 at 11:13 AM the surveyor requested the facility's Director of Nursing and Administrator to provide documentation which included medication administration audit reports for Resident #11. On 01/09/2026 at 12:00 PM the surveyor reviewed the facility provided medication administration audit reports for Resident #11 which revealed the following medications were not administered timely: 1. Gabapentin capsule 100mg Give 1 capsule by mouth three times daily scheduled for 1/7/26 at 8:00AM was documented by Certified Medication Assistant (CMA) #5 as administered on 1/7/26 at 10:59AM. 2. Losartan Potassium Tablet 50 MG Give 1 tablet by mouth in the morning scheduled for 1/8/26 at 7:00AM was documented by Registered Nurse #9 as administered on 1/8/26 at 8:37AM 3. Amlodipine Besylate Tablet 5MG Give 1 tablet by mouth in the morning scheduled for 1/8/26 at 7:00AM was documented by Registered Nurse #9 as administered on 1/8/26 at 8:38AM (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Aspirin Tablet 325 MG Give 1 tablet by mouth in the morning scheduled for 1/8/26 at 7:00AM was documented by Registered Nurse #9 as administered on 1/8/26 at 8:38AM 5. Buproprion HCl Extended Release Tablet 12 hour 150MG Give 1 tablet by mouth every morning and at bedtime scheduled for 1/5/26 at 7:00AM was documented by CMA #5 as administered on 1/5/26 at 8:42AM 6. Aspirin Tablet 325 MG Give 1 tablet by mouth in the morning scheduled for 1/5/26 at 7:00AM was documented by CMA #5 as administered on 1/5/26 at 8:42AM 7. Amlodipine Besylate Tablet 5MG Give 1 tablet by mouth in the morning scheduled for 1/5/26 at 7:00AM was documented by CMA #5 as administered on 1/5/26 at 8:42AM 8. Losartan Potassium Tablet 50 MG Give 1 tablet by mouth in the morning scheduled for 1/5/26 at 7:00AM was documented by CMA #5 as administered on 1/5/26 at 8:42AM 9. Losartan Potassium Tablet 50 MG Give 1 tablet by mouth in the morning scheduled for 1/6/26 at 7:00AM was documented by CMA #5 as administered on 1/6/26 at 8:45AM 10. Amlodipine Besylate Tablet 5MG Give 1 tablet by mouth in the morning scheduled for 1/6/26 at 7:00AM was documented by CMA #5 as administered on 1/6/26 at 8:45AM 11. Buproprion HCl Extended Release Tablet 12 hour 150MG Give 1 tablet by mouth every morning and at bedtime scheduled for 1/6/26 at 7:00AM was documented by CMA #5 as administered on 1/6/26 at 8:45AM 12. Aspirin Tablet 325 MG Give 1 tablet by mouth in the morning scheduled for 1/6/26 at 7:00AM was documented by CMA #5 as administered on 1/6/26 at 8:45AM 13. Gabapentin Capsule 100 MG Give 1 capsule by mouth three times a day scheduled for 8:00PM was documented as not having been administered until 9:27PM on 12/6/25. On 01/09/2026 at 12:25 PM the surveyor conducted an interview of CMA #5 who confirmed with the survey team that medication administration is documented at the time of the medication being administered. On 01/09/2026 at 12:46 PM the surveyor conducted an interview of Unit Manager, Licensed Practical Nurse (UM, LPN) #15 who reported to the survey team that some medications were liberalized with the administration time, however, they confirmed that medications including Gabapentin or medications given every 8 or 12 hours was not liberalized with the medication administration time. UM, LPN #15 further informed surveyors during the interview that if a resident refuses a medication the expectation is for them to document the refusal and if the resident refuses more than three times, they let the physician know, but if they refuse one time, they do not usually let the physician know. On 01/09/2026 at 12:51 PM the surveyor conducted an interview with the facility's Director Of Nursing (DON) and inquired as to if Gabapentin medication was liberalized with the medication administration time. The DON stated to the survey team, No it cant be liberalized. The DON reported to the survey team that the late administration of Gabapentin was wrong and the expectation was for staff to document the refusal in the medical record and notify the physician. When the surveyor (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requested for the DON to provide the facility's policy for liberalized medication administration, they stated to the survey team that there was no policy for liberalized medication administration.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, medical record review and interviews with facility staff it was determined the facility failed to prevent a medication error rate from exceeding above five percent, by administering medications outside of the scheduled time range resulting in a medication error rate of 14.81 percent. This was found to be evident for 2 (Resident # 103 and Resident # 107) of 6 residents observed during medication administration observation during the survey.Findings include,Type 2 Diabetes Mellitus is a chronic condition where the body either does not produce enough insulin or doesn't use insulin effectively causing blood sugar levels to rise. 1. A medication administration observation was conducted on 1/8/26 at 10:05 AM for Resident #103. Staff # 9, a registered nurse (RN) reviewed the computer screen as he poured medications for Resident # 03. The computer revealed a highlighted pink screen displaying the resident medication information for Aspirin Enteric Coated (EC) 81 mg tablet scheduled time of 8:00AM and medication information for Metformin 1000mg tablet displaying a scheduled time of 7:30AM. Staff # 9 administered Resident #103's medications at 10:05 AM. Review of the physician orders for Resident # 103 on 1/8/26 revealed the following:Metformin 1000mg give 1 tablet by mouth two times a day for Type 2 Diabetes before breakfast /dinner. Scheduled for 7:30AM. Metformin is an oral diabetic medication that is used to help control high blood sugar levels. Aspirin Enteric Coated (EC) 81 mg give 1 tablet by mouth 1 time a day for Cerebrovascular Accident (CVA). Scheduled for 8:00AM. Aspirin is used for preventative therapy against cardiovascular events such as heart attacks and strokes.Staff # 9 administered Resident # 103 medications outside of the scheduled physician ordered times. 2. A medication administration observation was conducted on 1/8/26 at 10:05 AM for Resident #107. Staff # 9 reviewed the computer screen as he poured medications for resident # 107. The computer revealed a highlighted pink screen displaying the resident medication information for Baclofen 10 mg tablet scheduled time of 8:00AM and medication information for Lyrica 75mg capsule displaying a scheduled time of 8:00AM. Another nurse, staff # 8 entered Resident #107's room at this time as staff # 9 was preparing the medications for Resident #107 and informed staff # 9 that she would administer the resident the scheduled Lyrica 75mg capsule. At this time staff # 8 administered Lyrica to Resident #107 at 10:15AM. Staff # 8 stated to the surveyor and staff # 9 that she was administering narcotics to the residents on the unit hall. Review of the physician orders for Resident #107 revealed the following:Baclofen 10 mg give 1 tablet by mouth three times a day for muscle spasm. Scheduled for 8:00AMLyrica 75 mg give 1 capsule by mouth three times a day for moderate to severe pain. Scheduled for 8:00AM.Staff # 8 and Staff # 9 administered Resident # 107's medications outside of the scheduled physician order times.An interview was conducted with staff # 9 at 10:30AM and he was asked why he administered the medications that were highlighted pink on the computer screen outside of the scheduled time range. He stated that the medications were administered late because he had to administer more than 10 other residents their medications prior and that he also had to obtain vital signs on the residents as well. Staff # 8 who was present in the hallway were interviewed at this time and she stated that she was there to assist.An interview was conducted with the DON on 1/8/26 at 2:20PM and she was made aware of the concerns identified during the medication administration observation and was asked what the expectation is for administering scheduled medications. The DON stated that during medication administration, if a pink screen displays or highlights on the computer screen, this is to alert the staff that the medication is late. She went on to say that when the pink screen is displayed, the staff are not to give the medication and are to notify the physician. The DON further stated that nurses are to notify the physician when medications are late and obtain a new order to administer the medication. She stated that education would be provided for the staff. All concerns were discussed with the Administration team at the exit conference on 1/9/26.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on interviews with the resident family, review of the medical record and interviews with facility staff it was determined that the facility failed to ensure that dental services were provided for a resident. This was found to be evident for 1 (Resident # 50) of 41 residents reviewed during the survey.The findings include: An interview was conducted with Resident # 50's family member on 1/5/26 at 2:22PM and the family member expressed a concern regarding the resident not being seen by the in-house dental services. The family stated that s/he had made this request at multiple care plan conferences and did not understand why it had not happened. When asked by the surveyor, the last time the resident was seen by the in-house Dentist, the family was unable to answer this. The family went on to say that the resident had bad breath as a result. The family further stated that they brought in mouth wash for the staff to use to rinse the resident mouth and that there was an approximate quarter amount remaining in the bottle. The surveyor observed a quarter of the amount of mouth wash remaining in the bottle during a follow-up observation on 1/8/26.Review of the resident medical record on 1/56/26 at 2:00PM revealed the following notes:Social Work (SW) Care Plan meeting held Thursday 2/27/25 at 11:30AM. SW to email Nursing on this. SW to also look into a dental appointment.SW Care Plan meeting held Monday 11/24/25 at 10:30AM. Oral care needs to be followed up. Spouse mentioned some concerns. SW to forward to Nursing.Resident needs a Dental appointment. Health Drive?An interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) on 1/8/26 at 9:20AM and they were asked to provide documentation of the facility's dental policy. The DON stated that the facility does not have a policy. She went on to say that the outside dental service company that the facility uses comes into the building to provide dental care to the residents. The DON stated that the resident and/or the resident family must submit a request for services and then the services will be provided. At this time the surveyor explained the care conference review findings and that a request was made by the family on 2/27/25 and again on 11/24/25 and if an appointment was made for the resident to be seen. She stated that she would have the Director of Social Work (DSW) speak to the survey team. An interview was conducted with the DSW on 1/8/26 at 9:40AM and she was asked to explain the facility's expectation and process for scheduling the residents for dental appointments when the request is made by family during care conference meetings. The DSW stated that consultations are usually handled by nursing, however, it was a team approach. During another meeting with the NHA and the DON on the same date at 1:00PM the DON explained to the survey team that nursing and social work are responsible for following up on recommendations and/or requests made and that the team dropped the ball, therefore the resident was not seen. The DON confirmed that there were multiple opportunities to get the resident seen and the facility failed to do so. All concerns were discussed with the Administration team at the exit conference on 1/9/26.

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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 record review and interviews with staff, it was determined that the facility failed to maintain medical records in accordance with accepted professional standards and practices. This was evident for 3 (Resident #114, Resident #42, and Resident #84) out of 41 residents reviewed during the annual survey. The findings include: 1. Hospice care means a comprehensive set of services identified and coordinated by an interdisciplinary group (IDG) to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care. This approach focuses on end-of-life comfort, dignity, and quality of life. On [DATE] at 11:00 AM, a review of Resident #114's electronic medical record revealed a discharge summary physician's note written on [DATE], which stated [he/she] was enrolled in hospice, rapidly declined, and expired on [DATE] at [1:56 PM]. The note also stated, After discussion with family, [he/she] transitioned to hospice care. Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice. This approach focuses on providing relief from the symptoms and stress of illness. Further review of Resident #114's electronic medical record failed to reveal a physician's order for hospice care, a plan of care, orders from the hospice agency, documentation of visitation and care provided by hospice staff, and a Minimum Data Set (MDS) assessment for significant change for the enrollment into hospice care. An additional review revealed orders for Hospice consult with [hospice company] provider and follow-up care as recommended-Unit Manager will speak with family first dated [DATE], Resident comfort care measures/palliative dated [DATE], No weight, no vital signs, comfort care measures dated [DATE], and No CPR, option B, Palliative and Supportive revision dated [DATE]. On [DATE] at 12:35 PM, during an interview conducted with Unit Manager #15, the Surveyor was informed that they believed Resident #114 was not in hospice care prior to his/her death and was provided comfort/palliative care as the family requested. UM #15 stated that they would review the resident's medical record to confirm. On [DATE] at 1:00 PM, during an interview with the Director of Nursing (DON) in the presence of the Nursing Home Administrator (NHA), the Surveyor expressed the concern that there was documentation in a physician's discharge summary for Resident #114 which stated the resident was enrolled in hospice care prior to his/her death on [DATE]; however, a review of Resident #114's electronic medical record failed to reveal a physician's order for hospice care, a plan of care and orders from the hospice agency, documentation of visitation and care provided by hospice staff, and an Minimum Data Set (MDS) assessment for significant change for the enrollment into hospice care. The DON stated they would look into the Surveyor's concern. On [DATE] at 2:15 PM, during an interview conducted with the DON in the presence of the NHA, the (continued on next page)

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	215341	A. Building B. Wing	01/09/2026

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor was informed that the resident was not enrolled in hospice care as stated in the physician's discharge summary note dated [DATE]. The resident was receiving palliative care at the time of his/her death. The DON provided the Surveyor with a Patient Orders document sent to the Nurse Practitioner (NP) on [DATE] at 8:05 AM, which stated that the Family remains wanting resident to be comfort care/palliative in this building with [doctor] and [nurse practitioner] assistance. Family does not request hospice care at this time, only comfort care/palliative care. The NP acknowledged the orders on [DATE] at 8:47 AM, the orders were marked as processed on [DATE] at 8:48 AM, and signed by UM #15. After reviewing the document in the presence of the DON and the NHA, the Surveyor expressed concern for and confirmed inaccurate documentation in Resident #114's medical record. 2. Antibiotics are antimicrobial substances that fight bacterial infections by either killing or inhibiting bacterial growth. Antibiotics do not work against viruses. On [DATE] at 1:00 PM, a review of Resident #42's electronic medical record revealed a physician's order for Rocephin Solution reconstituted 1GM. Use 1 gram Intravenously in the morning for viral infection for 5 days x 5 days to start on [DATE] at 7:00 AM, created by UM #15. On [DATE] at 2:35 PM, during an interview with the DON in the presence of the NHA, the Surveyor expressed the concern that Rocephin was ordered for Resident #42, and the indication for use was for viral infection. The Surveyor and the DON acknowledged that Rocephin is an antibiotic and does not treat viral infections. The DON stated that they would clarify the order with UM #15 and the NP. On [DATE] at 4:00 PM, during an interview with the DON in the presence of the NHA, the Surveyor was informed that the NP confirmed the order for Rocephin was necessary for the resident and stated that Resident #42 presented with respiratory distress upon their examination, and pneumonia was suspected. Rocephin is an antibiotic frequently used to treat pneumonia. A review of the NP's note dated [DATE] revealed that Respiratory distress was noted on today's assessment. Will treat empirically for concern for pneumonia pending [chest x-ray] results. The indication of use transcribed within the order was inaccurate. 3. On [DATE] at 1:00 PM, a review of Resident #42's electronic medical record revealed a physician's order for Rocephin Solution reconstituted 1GM. Use 1 gram Intravenously in the morning for viral infection for 5 days x 5 days to start on [DATE] at 7:00 AM, created by UM #15. Further review revealed a nursing narrative note written by Registered Nurse (RN) #20 on [DATE] at 10:36 AM, which stated, First dose of IV Rocephin 1GM in 250ml of 0.9% set up to run for 30 mins. IV Rocephin set up at 10:28 AM. On [DATE] at 2:35 PM, during an interview with the DON in the presence of the NHA, the Surveyor expressed the concern that Rocephin Solution reconstituted 1GM IV was ordered for Resident #42 to start on [DATE] at 7:00 AM, and according to a nursing narrative note written by RN #20, the medication was given this morning at 10:28 AM. Further review of the resident's electronic medical record failed to reveal an order for the Rocephin to start today. The DON stated they would look into the Surveyor's concern. On [DATE] at 2:45 PM, during an interview conducted with Infection Control Registered Nurse (ICRN) #16, the Surveyor was informed that Resident #42 was experiencing respiratory distress that had worsened since [DATE]. The NP stated that they wanted to treat the resident with Rocephin. The (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was given the medication this morning. The Surveyor and ICRN #16 reviewed the order and confirmed that the order start date was [DATE]. ICRN stated that the NP wanted the medication given today because of the resident's condition. On [DATE] at 3:00 PM, during an interview conducted with RN #20 in the presence of ICRN #16, the Surveyor was informed that they received a verbal order from the NP to give the Rocephin STAT (immediately) and that UM #15 transcribed the verbal order onto a Physician's Order Form. The Surveyor reviewed the Physician's Order Form, and an order received [DATE] at 8:50 AM, which stated Rocephin IV GM daily x5 days. STAT. Transcribed by UM #15 and signed by the NP. The Surveyor, RN #20, and ICRN #16 confirmed that the Rocephin was to be given [DATE] STAT. On [DATE] at 3:55 PM, during an interview with the UM #15 and the DON in the presence of the NHA, the Surveyor expressed the concern of accurate transcription of verbal orders from the physicians that are then entered into the resident's electronic medical record. According to Resident #42's physician orders in the electronic medical record, Rocephin was due to start [DATE] at 7:00 AM; however, a review of the hand documented Physicians Order Form revealed a verbal order dated [DATE] at 8:50 AM for the medication to be given STAT. RN #20 gave the medication at 10:28 AM based on the verbal order. UM #15 stated that RN #20 informed them that they transcribed the order incorrectly. The medication was to be taken today. UM #15 stated that since the medication had already been given, they adjusted the duration of the medication from x 5 days to x 4 days for the [DATE] order. 4. On [DATE] at 12:52 PM, the surveyor reviewed the medical record of Resident #84, which revealed inconsistency was present in the Resident's skin assessment documentation. On [DATE] at 2:19 PM the surveyor conducted an interview of the facility's Director of Nursing and inquired to them and shared the concern as to why Physician #13's medical progress note for Resident #84 dated [DATE] documented the following information: Skin- Diabetic wound of the left second toe, wound on right heel, when their skin assessment by Wound Care Certified Registered Nurse Practitioner #17 on [DATE] indicated that the Resident was to be discharged from wound care with healed wounds with recommended interventions to prevent new wounds from developing. After the surveyor's intervention, the Director of Nursing reported to the survey team on [DATE] at 3:25 PM that Physician #13 amended his/her note because the resident did not have the heel or toe issue at that time, and provided the surveyor with one amended note, which was observed. At this time, the surveyor shared their concern and requested copies of all physician progress notes requiring amendment, and the Director of Nursing acknowledged and confirmed understanding of the concern. After the surveyor's intervention, further review of Resident #84's medical record by the surveyor on [DATE] at 3:45 PM revealed that Physician #13 amended progress notes dated [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] to correct inaccurate wound documentation. Review of the medical record further revealed the following documentation present in Physician #13's addendum to their [DATE] medical progress note for Resident #84 dated as created on [DATE] at 3:04 PM: Review of wound care and patient examination revealed that diabetic foot wound had resolved, Right heel wound has also resolved, and This was incorrectly entered into note.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview it was determined the facility failed to ensure appropriate infection control measures was maintained for a resident's foley catheter bag. This was evident for 1 (#84) out of 1 Resident reviewed for urinary catheters during the facility's recertification survey. The findings include: During the surveyor's initial tour of the facility on 01/05/2026 at 8:52 AM the surveyor observed Resident #84's foley catheter bag laying directly on the floor's surface. On 01/05/2026 at 8:53 AM the surveyor conducted a dual observation and shared the concern with Unit Manager, Licensed Practical Nurse (UM, LPN) #15 who observed, acknowledged, and confirmed understanding of the concern. After surveyor intervention, UM, LPN #15 was observed by the surveyor picking Resident #84's foley catheter bag off of the floor's surface and hanging it up off of the floor. Review by the surveyor of the facility's provided urinary catheter care policy on 01/07/2026 at approximately 11:33 AM revealed the following information was present: The drainage bag and tubing should never be allowed to touch the floor. On 01/07/2026 at 2:04 PM the surveyor conducted an interview and shared concerns with the facility's Director of Nursing who acknowledged and confirmed understanding of the concerns and confirmed with the surveyor that the foley catheter bag should be stored off of the floor to prevent infection.