STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215240	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Moran Nursing and Rehabilitation Center	25701 Shady Lane Southwest Westernport, MD 21562

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 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. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and facility document and policy review, the facility failed to revise the care plan for 1 (Resident #14) of 9 residents reviewed for care plans. Specifically, the facility failed to revise Resident #14's care plan to include a history of drug abuse and an incident when the resident was found unresponsive and positive for fentanyl (a potent opioid drug), which was not prescribed for the resident. Findings included:A facility policy titled, Care Plan Process, Person-Centered Care, revised 05/05/2023, indicated, 6. The Interdisciplinary Team (IDT) will review for effectiveness and revise the person-centered care plan after each assessment. This includes both the comprehensive and quarterly assessments. The policy also revealed, 9. Thru [sic] ongoing assessment, the facility will initiate person-centered care plans when the resident's clinical status or change in condition dictates the need such as but not limited to falls and pressure ulcer development. A Resident Face Sheet indicated the facility admitted Resident #14 in April 2023. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following cerebral infarction (stroke), hepatic encephalopathy, dysphagia, aphasia, and vascular dementia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/20/2025, revealed Resident #14 had moderate impairment in cognitive skills for daily decision-making and had a short-term memory problem per a Staff Assessment of Mental Status (SAMS). Resident #14's nursing Resident Progress Notes, dated 03/11/2025 at 6:06 PM revealed staff found the resident unresponsive, not responsive to voice, touch, or a sternal rub. A Facility Reported Incidents Initial Report Form, dated 03/12/2025, revealed Resident #14 was found unresponsive on 03/11/2025 at approximately 6:06 PM. The form revealed nursing staff notified the physician, who ordered the resident to be transferred to the emergency room (ER). The form revealed that at the hospital, the resident was positive for fentanyl; however, the resident was not prescribed the medication while in the facility. Resident #14's emergency room (ER) Observation Note, dated 03/11/2025, indicated the resident was unresponsive and emergency medical services (EMS) administered Narcan (a medication that rapidly reverses the effects of an opioid overdose), and the resident's symptoms improved. The note revealed that the resident's urine screen dated 03/11/2025 was positive for fentanyl. According to the ER Observation Note, Resident #14 had a history of drug abuse, and past medical history included a stroke secondary to a suicide attempt/overdose. A Facility Reported Incident Follow-Up Investigation Report, dated 03/19/2025, revealed the facility educated staff on the signs/symptoms of opioid over consumption and the facility would review the resident's progress notes and vital signs as part of their clinical morning stand-up meetings. Resident #14's Care Plan, last reviewed/revised 10/11/2025, revealed no documented evidence the facility revised the resident's care plan to address the resident's history of drug abuse or the 03/11/2025, ER visit when the resident tested positive for fentanyl, a medication they were not prescribed. During an interview on 10/23/2025 at 10:57 AM, the MDS Coordinator stated there was no reason Resident #14's care plan was not updated with their history of drug abuse or testing positive for fentanyl.During an interview on 10/22/2025 at 12:27 PM, the Assistant Director of Nursing (ADON) stated she did not know why Resident #14's history of drug abuse and the fentanyl incident were not on the resident's care plan. During an interview on 10/22/2025 at 3:08 PM, the Director of Nursing (DON) stated Resident #14's history of drug abuse and the incident of testing positive for fentanyl should have been added to the resident's care plan. During an interview on 10/22/2025 at 3:46 PM, the Administrator stated after the incident they monitored family visits for a while; however, Resident #14's care plan was not revised because it was a one-time incident, and there had been no incidents since.

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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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and facility policy review, the facility failed to ensure staff donned all required personal protective equipment (PPE) prior to providing incontinence care and failed to ensure staff followed the facility's hand hygiene policy/procedure for 1 (Resident #8) of 1 resident reviewed for infection control.Findings included:A facility policy titled, Transmission Based/Standard Precautions, and Enhanced Barrier Precautions (EBP), revised 05/15/2023, revealed, B. EBP will be implemented during the following high-contact resident care activities: 1) Dressing, 2) Bathing/showering, 3) Transferring, 4) Providing hygiene, 5) Changing linens, 6) Changing briefs or assisting with toilet, 7) Device care or use: central lines, urinary catheter, feeding tube, tracheostomy/ventilator. The policy further revealed, C. EBP requires the following PPE: 1) Gloves, 2) Gown, and 4) All PPE is donned and doffed with appropriate hand hygiene and disposable [sic] after individual use or when visibly soiled.A Resident Face Sheet revealed the facility admitted Resident #8 on September 2024. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of infection and inflammatory reaction due to other urinary catheter and need for assistance with personal care.An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/24/2025, revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had an indwelling catheter and was dependent on staff for toileting hygiene.Resident #8's Care Plan, included a problem statement initiated 09/18/2025, that indicated the resident had an indwelling urinary catheter. Interventions directed staff to follow appropriate infection precautions during care, including EBP for residents with a urinary catheter (initiated 09/18/2025).During an observation on 10/21/2025 at 10:04 AM, Geriatric Nurse Aide (GNA) #19 and Certified Nursing Assistant (CNA) #20 answered the call light for Resident #8 and the resident requested assistance with incontinence care. Prior to providing care, GNA #19 and CNA #20 did not don a gown, despite signs that were visible on Resident #8's door indicating the resident required EBP. The observation revealed gowns were also visible outside Resident #8's door.During the observation, GNA #19 and CNA #20 donned gloves, and Resident #8 turned toward CNA #20. A large amount of liquid stool was visible on Resident #8's buttocks and lower back. GNA #19 wiped the resident's perineal area from front to back, then washed the resident's buttocks with a wet washcloth. GNA #19 then patted the resident dry with a clean towel. Without changing gloves, with GNA #19's left hand, he grabbed Resident #8's left hand and assisted the resident to turn towards him. The observation revealed CNA #20 wiped stool from the resident's left side, washed the resident's left side with a wet washcloth, and then patted the resident dry with a clean towel. The observation revealed GNA #19 then removed his gloves, washed his hands with soap and water, and applied new gloves. Resident #8 turned onto their back and GNA #19 removed the resident's shirt and washed the resident's right side. With the same gloved hands that were used to clean stool, CNA #20 washed the resident's left side, grabbed the resident's deodorant, and handed the deodorant to GNA #19. GNA #19 applied deodorant to the resident's left armpit and handed it back to CNA #20. CNA #20 applied deodorant to the resident's right armpit and placed the deodorant back on the resident's bedside table. GNA #19 and CNA #20 applied a clean brief and a clean shirt for the resident. Again, with the same gloved hands used to clean stool, CNA #20 used the bed remote to adjust the bed. CNA #20 then removed her gloves for the first time and washed her hands with soap and water. GNA #19 removed his gloves and washed his hands with soap and water before leaving the room.During an interview on 10/21/2025 at 10:44 AM, GNA #19 stated he probably should have put a gown on since Resident #8 had a catheter. GNA #19 stated he also should have changed his gloves and performed hand hygiene more often.During an interview on 10/21/2025 at 10:55 AM, CNA #20 stated she should put on a gown when providing incontinence care to residents on EBP. CNA #20 stated Resident #8 was on EBH, but she was not sure when to wear a gown when providing care to the resident. CNA #20 stated she should have changed her gloves after wiping the resident, but she was nervous.During an interview on 10/22/2025 at 9:13 AM, the Quality Assurance/Infection Prevention (QA/IP) Nurse stated that if a resident had a catheter, the resident was placed on EBP. The QA/IP Nurse stated that staff should wear gloves and a gown when personal care was provided. The QA/IP nurse stated that staff should change gloves if they became soiled and could change gloves at any time. The QA/IP Nurse stated she and the Assistant Director of Nursing (ADON), unit managers, and the Director of Nursing (DON) monitored staff for proper hand hygiene and infection control. During an interview on 10/22/2025 at 10:24 AM, the ADON stated staff were expected to change gloves if