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	03/06/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interviews, and record review, the facility failed to give clean and safe incontinence care for 1 resident (Resident #12) out of a universe of 1 resident reviewed for incontinence care. The staff did not keep clean and dirty items separate, did not change gloves when needed, did not follow hand hygiene steps, and did not follow enhanced barrier precaution rules. This failure placed the resident at risk for infection.Review of facility nursing policy and procedures titled, Perineal and Incontinence Care dated 5/5/23 documented, Using gentle downward strokes, clean from the front to the back of the perineum to prevent intestinal organisms from contaminating the urethra or vagina. Avoid the area around the anus and use a clean section of wash cloth for each stroke by folding each used section inward .If you're using soap and water, wet a clean washcloth and rinse the perineum thoroughly from front to back, because soap residue can cause skin irritation. Pat the area dry with a bath towel .Clean, rinse, and dry the anal area, starting at the posterior vaginal opening and wiping from front to back .Gather and prepare the necessary equipment and supplies. Perform hand hygiene .Raise the patient's bed to waist level before performing care .Perform hand hygiene. Put on gloves, gown, and mask, as needed, to comply with standard precautions.Review of the medical record for Resident #19 revealed an admission date: 4/9/24. Diagnoses included type 2 diabetes and need for help with personal care. The care plan documented the resident was always incontinent, had a colostomy, and was at risk for repeated urinary tract infections. Bathing orders: Wednesday and Sunday, day shift. On 3/5/26, the resident received a partial bed bath with total staff assistance.Perineal hygiene assessments on 3/4/26 and 3/5/26 showed the resident required substantial to maximal assistance.On 3/5/26 from 10:51 a.m. to 11:15 a.m., an observation of incontinence care for Resident #12 showed: The Geriatric Nursing Assistant (GNA) C touched the bedside table, the blanket covering the resident, dirty linen, closet handles, and clean linen without changing gloves. GNA C handled clean towels, clean sheets, and the faucet with the same gloves used for dirty items. The GNA did not know whether the resident remained on enhanced barrier precautions. GNA C used wet towels removed from the trash bin to clean the resident's genital area. The GNA placed used towels on clean surfaces, including the clean sheet next to the resident. The GNA continued care tasks, including wiping between the buttocks and washing the thighs and knees, without changing gloves. After applying prescription zinc cream, the GNA touched the bedside table with contaminated gloves. At 11:12 a.m., the GNA removed gloves and gown, placed them in the trash, did not wash hands, and exited the room.At 11:15 a.m., the GNA reˆentered the room, put on gloves, and washed the resident's face.During an interview with the Regional Ombudsman (RO O) on 3/4/26 at 10:02 a.m. reported ongoing concerns about quality of care, agency staff not knowing routines, slow call light response, and staff sharing personal staffing issues with residents.During an interview with the Nurse Manager (Licensed Practical Nurse) LPN B on 3/5/26 at 11:19 a.m. stated staff were expected to know the steps of incontinence care, including wiping frontˆtoˆback, changing gloves between dirty and clean tasks, washing hands, and gathering all supplies before starting care. LPN B confirmed Resident #12 was on enhanced barrier precautions due to a colostomy.In an interview with Director of Nursing (DON) on 3/5/26 at 3:34 p.m. stated staff were expected to change gloves, wash hands or use hand sanitizer, and follow cleanˆtoˆdirty steps during care.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to follow infection^control practices for 3 residents (Residents #12, #2, and #7) out of a universe of 3 residents reviewed for infection control. Staff did not perform hand hygiene, did not change gloves when required, did not keep clean and dirty items separate, did not follow safe medication^administration practices, and did not follow safe catheterization procedures. These failures placed residents at risk for infection, cross^contamination, and harm.Review of facility policy, titled Hand Hygiene/Handwashing dated 2022 documented, Hand Hygiene/Hand washing is the most important component for preventing the spread of infection. Maintaining clean hands is important for patients/residents/visitors as well as staff .Procedures: 1. Hand hygiene/hand washing is done: Before: A. Before patient/resident contact .After: A. After contact with soiled or contaminated articles, such as articles that are contaminated with body fluids. B. After patient/resident contact. C. After contact with a contaminated object or source where there is a concentration of microorganisms, such as, mucous membranes, non-intact skin, body fluids or wounds. D. After toileting or assisting others with toileting, or after personal grooming .H. After removal of medical/surgical or utility gloves .If glove hands become contaminated as gloves are changed hands can be washed. I. Contact with a patient's/resident's intact skin (e.g. taking a pulse or blood pressure, performing physical examinations, lifting the patient/resident in bed. J. Contact with environmental surfaces in the immediate vicinity of patients/residents .2. Wash hands: .C. Before putting on gloves, when changing into a fresh pair of gloves, and immediately after removing gloves. Review of medical records for Resident #12 revealed admission: [DATE] a diagnoses that included type 2 diabetes and need for help with personal care. A Care plan: that showed the resident was always incontinent, had a colostomy, and was at risk for repeated urinary tract infections. Bathing orders: for Wednesday and Sunday, day shift. On 3/5/26, the resident received a partial bed bath with total staff assistance. Perineal hygiene assessments on 3/4/26 and 3/5/26 showed substantial to maximal assistance was required.An observation of incontinence care for Resident #12 on 3/5/26 from 10:51 a.m. to 11:15 a.m. showed: The Geriatric Nursing Assistant (GNA)C touched the bedside table, the blanket covering the resident, dirty linen, closet handles, and clean linen without changing gloves. The GNA handled clean towels, clean sheets, and the faucet with the same gloves used for dirty items. GNA C did not know whether the resident remained on enhanced barrier precautions. The GNA used wet towels removed from the trash bin to clean the resident's genital area. The GNA placed used towels on clean surfaces, including the clean sheet next to the resident. The GNA continued care tasks, including wiping between the buttocks and washing the thighs and knees, without changing gloves. After applying prescription zinc cream, the GNA touched the bedside table with contaminated gloves. At 11:12 a.m., the GNA removed gloves and gown, placed them in the trash, did not wash hands, and exited the room. At 11:15 a.m., the GNA re^entered the room, put on gloves, and washed the resident's face.In an interview with the Regional Ombudsman (RO O) on 3/4/26 at 10:02 a.m. reported ongoing concerns about quality of care, agency staff not knowing routines, slow call light response, and staff sharing personal staffing issues with residents. Nurse Manager Licensed Practical Nurse (LPN) B on 3/5/26 at 11:19 a.m. stated staff were expected to wipe front^to^back, change gloves between dirty and clean tasks, wash hands, and gather all supplies before starting care. LPN B confirmed Resident #12 was on enhanced barrier precautions due to a colostomy.The Director of Nursing (DON) on 3/5/26 at 3:34 p.m. confirmed staff were expected to change gloves, wash hands or use hand sanitizer, and follow clean^to^dirty steps during care.A record review of Resident #2 showed and admission date of 1/15/25, and documented diagnoses that included spinal stenosis, bilateral lower-extremity weakness, vertigo, muscle weakness, neuropathy, and bone disorder.An observation of medication administration for Resident #2 on 3/4/26 at 7:40 a.m. revealed: Licensed Practical Nurse (LPN) A did not perform hand hygiene before entering the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN A did not sanitize hands before putting on gloves. The LPN administered 11 medications without performing hand hygiene between tasks. During insulin preparation, the right glove ripped, and LPN A continued the procedure with only the left hand gloved. With a bare hand, LPN A wiped the injection site with alcohol and administered the insulin injection. The LPN did not wash or sanitize hands after glove removal.Review of Resident #7's medical record noted the resident was admitted on [DATE]. Resident #7's diagnoses included: Active progressive multiple sclerosis, paraplegia, adult failure to thrive, personal history of urinary tract infections, vitamin B12 deficiency anemia, pain, unspecified Osteoarthritis, unspecified site, neuromuscular dysfunction of the bladder.The Grievance Log documented a care concern reported on 2/12/26, which the facility marked as resolved on 2/19/26. The Minimum Data Set (MDS) showed: Quarterly MDS dated [DATE]: BIMS score of 15; toileting hygiene was dependent; urinary continence was always incontinent. Annual MDS dated [DATE]: BIMS score of 15; toileting hygiene was dependent; urinary continence was always incontinent. The Care Plan documented: The resident reported signs and symptoms of a urinary tract infection even when urine tests were negative and requested antibiotics.The resident was at risk for negative psychosocial outcomes related to expressing multiple care concerns and making an allegation of abuse.The resident showed mild changes in cognitive function, including problems with information processing, attention, and concentration, and showed cognitive biases toward staff related to multiple sclerosis. The resident had altered urinary elimination related to multiple sclerosis and neurogenic bladder, with a history of repeated urinary tract infections and incontinence. Physician orders showed the resident required toileting with the help of 1-2 staff. Progress notes included: 12/31/25: A catheterization was attempted for a urine culture. Very little urine was obtained, not enough for testing. The resident asked to continue the ordered antibiotic (Macrobid 100 mg twice a day for 7 days) and refused another catheterization. The provider was notified and discontinued the urine culture order. 12/28/25: The resident reported seeing fecal matter on the tip of the catheter and stated it had been inserted into the urethra with fecal matter on it. The nurse documented that she reassured the resident this was not true, but the resident continued to state otherwise. 12/28/25: A urine sample was obtained by straight catheterization. The urine was dark yellow and concentrated, and the resident tolerated the procedure.A review of the complaint and facility reported incident based on the same situation noted that Resident #7 reported that during a straight catheterization for a urine sample, Registered Nurse F: Touched the wrong area and poked near the anus while trying to find the urinary opening.Inserted the catheter into the vagina, and the resident shouted that it was the wrong place. Then inserted the catheter into the urinary tract, which caused pain. Pressed on the resident's abdomen to obtain more urine, even after the resident said it hurt. Stated that the catheter came out and ended the procedure. The resident reported feeling upset, in pain, and distressed by the procedure and stated they did not want that nurse to care for them again. In an interview with the Social Services (SOC) G on 3/5/26 at 2:30 p.m. they stated that Resident #7 reported the allegation by email; the Social Worker did not recall the exact date but felt the email needed to be sent to the Director of Nursing and Administrator for investigation. The resident reported that the catheter was placed in the anus. Resident #7 appeared upset and frustrated and felt that RN F should have been able to perform the procedure correctly. The resident stated that they did not want RN F to perform procedures or engage with that nurse again. The resident's description of the event stayed consistent in repeated conversations with the Social Worker. Resident #7 was alert and oriented and had a BIMS score of 15. The Social Worker described the resident as sometimes difficult to investigate because they brought up past issues that had already been resolved. The Social Worker met with the resident several times, monitored psychosocial status, and stated that reˆeducation for the nurse was done and communicated to the resident. Advocacy and counseling services were offered; the resident declined. When the resident was adamant about not wanting certain staff, those staff were removed from that assignment to support the resident's sense of safety.In an interview with the Infection Preventionist / Staff Development (RN) E on 3/5/26 at 2:58 p.m. The Infection Control Staff Development Coordinator (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated: They were asked by administration to provide an inˆservice on straight catheterization for RN F. A mannequin was used and the nurse demonstrated the procedure and did it perfectly, and RN E had no concerns at that time. RN E reported that an infectionˆcontrol boot camp for staff had been provided, including isolation types, personal protective equipment, and hand washing, and did this for new hires and agency staff. They had also inˆserviced the GNA C on perineal care, including Hand sanitizing and gathering all equipment before care. Working from outer to inner areas, front to back. Not using dirty washcloths or linens again. Changing gloves after dirty care and between new briefs.Hand sanitizing or washing hands before putting on gloves and after gloves were torn or soiled. RN E stated that the expectations for medication pass included hand hygiene before/after, between residents and washing hands when visibly soiled. RN E was not sure when the last incontinenceˆcare inˆservice had been done.An interview with the DON on 3/5/26 at 3:34 p.m. revealed the DON first became aware of the resident's allegation after the Social Worker shared the resident's email following a holiday weekend. Resident #7 reported that the nurse placed the catheter in the rectum, then the vagina, and then the urethra, and that the resident was particular about how far her legs could be spread due to prior injuries. The nurse reported that the catheterization was difficult because the resident would not allow her to spread the legs fully. The facility interviewed the resident, the nurse, and the aides present and told the nurse they would receive competency checks. The DON stated that RN F had performed many catheterizations and usually worked night shift. When asked the DON did not know when the nurse's last catheterization competency was completed. The DON stated that catheterization was a sterile procedure and that the expectation was to keep the procedure as clean and sterile as possible, with clean gloves and careful technique. They reported that when the resident did not want the nurse to care for them, the DON followed up with RN F and told the nurse that the resident did not want RN F assigned to them. The DON stated they were aware that the nurse had returned to the resident's room after the event to retrieve the catheter from the trash after being told it should not have been thrown away, and that this was not consistent with how the DON would have expect the procedure to be handled.