| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 215240 | A. Building<br>B. Wing | 05/15/2026 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and observations, it was determined that the facility failed to follow guidance from the Maryland Department of Health (MDH) and the facility's corrective action plan to prevent the risk of exposure to Legionella and failed to ensure infection control practices were implemented to minimize the potential spread of pathogens, including maintaining a designated handwashing sink, appropriate use of personal protective equipment (PPE), and proper cleaning of equipment. This was evident for 1 of 1 Legionella corrective action plans reviewed and 3 of 3 infection control practices observed while performing the infection control task during the annual survey.The findings include:1.) There is significant risk for Legionella bacteria growth when shower lines in a long-term care facility are left stagnant or unused. Stagnant water promotes biofilm formation, creating an ideal environment for Legionella multiplication. Aerosolized contaminated water can expose residents during shower use, placing elderly and immunocompromised residents at increased risk for Legionnaires' disease, a severe form of pneumonia.<br><br>On 5/11/26 at 1:10 PM, during the initial screening process, Resident #4 reported ongoing water issues. Observation of the resident's private bathroom revealed multiple personal items piled in the shower, preventing use. Resident #4 stated they had been told the shower could not be used due to water issues and were required to shower in the community shower down the hall.<br><br>On 5/11/26 at 1:59 PM, the surveyor interviewed the Maintenance Director (Staff #14), who acknowledged ongoing water issues due to the age of the building. When asked why Resident #4's shower was inaccessible, he stated residents were not permitted to use private showers and were required to use community showers.<br><br>On 5/13/26 at 10:38 AM, GNA #18 confirmed there had been ongoing water issues related to possible Legionella and stated resident room showers were not to be used, although some remained operational.<br><br>On 5/13/26 at 11:40 AM, the surveyor again interviewed the Maintenance Director (Staff #14), who confirmed he was aware residents had been instructed not to use room showers but stated he was unsure why. When asked about Legionella concerns, he acknowledged there had been issues in the past. He stated showers were not tested because they were not used and that most of the water access to the showers has been turned off.<br><br>On 5/13/26 at 11:52 AM, the Maintenance Director (Staff #14) stated showers were not routinely flushed and were only flushed if drains produced an odor. He further stated, housekeeping flushes the sinks on occasion and initially reported there was no official log documenting the flushing.<br><br>On 5/13/26 at 12:00 PM, the surveyor reviewed Legionella documentation provided by the<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Maintenance Director and identified a document titled 3/2/26 Summary of Legionella Testing and Prevention Activities since 12/29/25. The document reflected positive hot water Legionella test results on 1/7/26 and again on 1/29/26 in two separate resident rooms. The local health department was notified and, because no residents tested positive, directed the facility to complete remediation activities as recommended by the water treatment specialist (NALCO), including flushing affected lines, replacing fixtures as needed, retesting, and ongoing daily flushing of room water lines by staff as part of continued prevention efforts.<br><br>On 5/13/26 at 12:10 PM, the surveyor interviewed the Environmental Services Director (Staff #15), who stated he was newly hired and unaware of a checklist or process requiring daily flushing. During this interview, Housekeeper (Staff #16) stated staff were expected to flush sinks daily but confirmed resident room showers were not flushed and only public showers were run. Staff #16 stated logs were completed and returned monthly to Maintenance.<br><br>On 5/13/26 at 12:17 PM, the surveyor again questioned the Maintenance Director regarding flushing logs. He then produced logs after previously stating none existed and replied, I wasn't trying to hide anything, I must have misunderstood what you were asking for. He further confirmed there was no log identifying which resident room showers were operational versus shut off.<br><br>On 5/13/26 at 12:24 PM, the surveyor interviewed the Nursing Home Administrator (NHA) and Director of Nursing (DON) regarding resident room showers. Both stated showers were not used for safety purposes due to fall risk. The NHA confirmed two sinks had previously tested positive for Legionella and stated all resident showers except room [ROOM NUMBER] had been shut off.<br><br>On 5/13/26 at approximately 12:38 PM, two surveyors tested showers in Rooms 308, 307, 322, 316, and 317. All showers were operational except room [ROOM NUMBER], contradicting the facility's statement that resident room showers had been shut off.<br><br>On 5/13/26 at approximately 1:30 PM, the surveyor reviewed additional Legionella documentation and identified a 1/8/26 email from the local health department to the Infection Preventionist (ICP #3), directing the facility to implement enhanced surveillance, including evaluating residents with respiratory symptoms for pneumonia, ordering chest x-rays, immediately reporting new pneumonia cases, performing Legionella diagnostic testing, maintaining line lists of respiratory illness, designating a staff member to conduct surveillance, and maintaining surveillance for six months following the last facility-associated case.<br><br>On 5/13/26 at 3:09 PM, the surveyor interviewed ICP #3, who acknowledged awareness of prior positive Legionella findings within a sink but stated residents were only tested for Legionella after a confirmed pneumonia diagnosis and not when presenting with respiratory symptoms. Review of respiratory illness line listings revealed 16 residents experienced respiratory-related symptoms in March 2026, including shortness of breath, wheezing, runny nose, chills, and rhonchi. Of those residents, three were diagnosed with pneumonia, two with bronchitis, and two tested positive for Human Metapneumovirus (HMPV). ICP #3 confirmed only residents diagnosed with pneumonia were tested for Legionella, confirming the facility failed to implement enhanced Legionella surveillance as directed by the local health department for residents presenting with respiratory symptoms.<br><br>On 5/13/26 at approximately 3:30 PM, the surveyor reviewed sink flushing logs and noted incomplete documentation. Logs lacked dates, room numbers, staff identifiers, and did not reflect daily flushing as required by the facility's written remediation plan. Shower flushing was not included.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 5/13/26 at 3:40 PM, the surveyor interviewed the Regional Clinical Director (RCD #11) and NHA regarding concerns related to unmonitored showers, incomplete flushing documentation, and failure to follow local health department guidance for resident surveillance. Both acknowledged these concerns.<br><br>On 5/13/26 at 4:15 PM, the surveyor reviewed the local health department guidance email with ICP #3, who stated she had misunderstood the guidance and confirmed residents with respiratory symptoms had not been tested as directed.<br><br>On 5/13/26 at 4:22 PM, the surveyor interviewed the RCD (#11), NHA, DON, and Maintenance Director (#14). The Maintenance Director confirmed there was no log identifying which showers were operational, resident room showers were not flushed daily, sink flushing was inconsistently performed and poorly documented, and stagnant shower lines created Legionella risk. All present agreed these practices were not consistent with the facility's documented Legionella prevention plan dated 3/2/26.<br><br>On 5/14/26 at 11:55 AM, the surveyor interviewed facility administration regarding Quality Assurance Performance Improvement (QAPI) oversight of the Legionella issue. The facility later confirmed the Legionella issue had not been incorporated into QAPI for monitoring and follow-up.<br><br>Cross Reference F867<br><br>2.) On 05/12/2026 at 11:45 AM, the surveyor noted that a commercial-grade handwashing sink was not available in either of the two soiled laundry rooms. One soiled laundry room was used for sorting laundry into four different bins, while the second room was used for loading soiled laundry into the washing machines. Only one utility sink was located in the corner of the laundry machine room directly below the wall-mounted paper towel and soap dispensers. An interview with the Healthcare Services Group Environmental Services (EVS) Director confirmed that the utility sink was being used as an eye washing station, soiled laundry soaking station, and a handwashing sink.<br><br>At 2:40 PM, a follow-up tour of the laundry rooms was conducted with the Maintenance Director. During the interview, the Maintenance Director confirmed that there were no designated handwashing sinks in either of the soiled laundry rooms to support proper hand washing practices.<br><br>At 3:30 PM, a tour of the third-floor soiled utility room was conducted with the Maintenance Director. During the tour, the surveyor noted that the hopper was visibly damaged and labeled with an OUT OF ORDER sign. An interview with the Maintenance Director confirmed that the specialized clinical sink would be replaced as soon as possible to clean and sanitize bedpans, urinals, and basins for proper disposal of liquid and semi-solid waste and bodily fluids.<br><br>On 5/14/2026 at 10:30 AM, a second follow-up tour of the laundry rooms was conducted with the Infection Preventionist (IP) and the EVS Director. During the tour, the surveyor addressed that the two separate soiled laundry rooms lacked designated handwashing sinks and the laundry machine room lacked appropriate PPE, including gowns, gloves, and eye googles for staff handling soiled laundry. The IP acknowledged that designated handwashing sinks were required and stated that PPE would be provided in both soiled laundry rooms as soon as possible. Furthermore, the nonfunctional hopper on the third-floor soiled utility room would be replaced to minimize the risk of possible cross-contamination. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, and interview with facility staff, it was determined that the facility failed to maintain food service equipment in a manner that ensures sanitary food service operations to prevent possible foodborne illness. This was evident during the kitchen tour of the annual survey. The findings include:A food-contact surface refers to any surface of equipment and utensils that typically comes into contact with food; or from which food may drain, drip, or splash onto food; or a surface that is usually in contact with food. On 05/12/2026 at 9:25 AM, the surveyor conducted a tour of the kitchen alongside the Certified Dietary Manager (CDM) and identified the following deficient practices:Multiple cove base tiles were missing throughout the kitchen areas creating gaps and holes along the walls that could harbor pests and bacteria.Food carts, hot plate warmers, and dish tray rolling racks were unclean and heavily soiled with dust, dirt, debris, and accumulated food spills. The drywall underneath the dish machine, measuring about 24 inches by 36 inches, was in disrepair with significant chipping and peeling paint along with accumulation of dirt, dust, and food spills.Steam, vapor, and heat were observed escaping from the high-temperature conveyor dish machine. In addition, the surrounding walls and caulked edges showed significant buildup of mold-like substances. The kitchen environment was warm and humid with stagnant air, indicating insufficient airflow from the canopy hood ventilation system, and the local exhaust system in the designated wash-down area located at the corner of the kitchen.The wall-mounted fans were unclean and had excessive buildup of dust, dirt, and debris. The stainless-steel floor panels and the thresh board plates in the walk-in coolers were lifted, buckled, and warped, creating gaps for buildup of dust, dirt, and food spills.At 2:05 PM, a follow-up tour of the kitchen was conducted with the Maintenance Director and CDM to go over the findings listed above. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on observations, interviews, and record review, it was determined that the facility failed to treat residents with respect and dignity, as evidenced by failing to knock and request permission before entering a resident's room. This was evident for one (Resident #31) of one Resident reviewed for dignity. The findings include:On 5/13/26 at 6:57 AM, an observation showed that Resident #31 had activated the call light for help. Staff #13, a nursing assistant, entered Resident #31's room in response to the call light, and the surveyor was also present in the resident's room. The observation failed to show that Staff #13 knocked on the resident's door, announced herself, or requested permission before entering the resident's room.During an interview at that time, Staff #13 was asked whether she knocked on Resident #31's door before entering the room. Staff #13 indicated that Resident #31's door was already open, so she did not knock. Staff #13 then added that she should have announced herself, even though the resident could not answer her anyway.A record review later that day included progress notes indicating that Resident #31 was alert and oriented but had difficulty communicating due to a history of aphasia. However, Resident #31 communicated his/her needs using a communication board and signs/gestures, made himself/herself understood, and was usually understood by others.In an interview on 5/14/26 at 11:08 AM, the assistant director of nursing (ADON) reported that staff #13 had already informed her that the surveyor had expressed concern about not knocking on Resident #31's door before entering. The ADON added that she expected that staff would knock and announce themselves before entering any resident's room. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on review of the medical record, facility investigation documentation and interviews it was determined that the facility failed to keep a resident free from abuse. This was found to be evident for one (Resident #21) of four residents reviewed for abuse during the survey.The findings include:Review of the medical record revealed Resident #21 is a long-term care resident who is cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. The resident has severely impaired vision and requires assistance for transfers and toileting.Review of the Facility Reported Incident (FRI) #2967650 Initial Report Form, submitted on 3/29/26 at 11:50 PM, revealed an allegation that Nurse #6 heard a verbal exchange between Resident #21 and nursing assistant (NA) #9 while the NA was toileting Resident #21. During this exchange NA #9 was shouting at Resident #21 and using foul language. NA #9 loudly shut Resident #21's bathroom door after Resident #21 asked her not to close the door. Review of the facility investigation documentation revealed a signed statements from Nurse #6. Review of Nurse #6's statement revealed that Resident #21 had turned on the call light and was yelling out for help. Prior to going into the room NA #9 yelled out loudly that they had 30 other residents to care for and [s/he] did not have to yell. NA #9 then went into the resident's room and loud yelling was heard with curse words. The aide came out of the room and the resident yelled for her to open the door. The aide yelled something and went back into the room and loud - very loud door slam was heard. This statement indicated the Medicine Aide was also a witness to the event.Further review of the investigation documentation revealed a signed statement from Medicine Aide #7. This statement revealed the event occurred around 8:00 PM on Sunday 3/29/26. This statement also indicated Resident #21 had turned on the call light and was yelling out that s/he needed help. Prior to NA#9 entering the resident's room, NA #9 was yelling out that she has 30 some residents to take care of also. NA #9 went into the resident's room, and the Nurse and Medicine Aide could hear yelling back and forth, including some cuss words. Medicine Aide also heard a loud door slam and more yelling.On 5/14/26 at 3:02 PM Medicine Aide #7 reviewed his/her statement and confirmed the contents were accurate. Medicine Aide #7 also reported that the NA's voice was different from the residents and that the NA was cussing. Medicine Aide #7 reported that the nurse indicated she would go and take care of the situation. Medicine Aide #7 also reported that she told the nurse she needed to call outside the building. Surveyor clarified with Medicine Aide #7 that she meant the nurse should contact the administrative staff when she said call outside the building.Review of the facility's policy on Abuse, Neglect, Exploitation, or Mistreatment (revision date of 10/23/19) revealed in Component V: Reporting/Response 1. All alleged violations concerning abuse, neglect, or misappropriation of property are reported verbally immediately to the Facility Abuse Coordinator, the Administrator and to other officials in accordance with state law including the State Surve and Certification Agency.Further review of the initial report revealed the incident occurred on 3/29/26 at 7:30 PM but was not reported to the administration until 11:00 PM.Further review of the Abuse policy revealed in Component VII: Protection 1. During the investigation, the facility protects the patient/resident , as appropriate, including but not limited to the following: A. Removal of the alleged abuser from the patient/resident care setting.Review of the staffing schedules revealed nursing assistant's evening shifts are from 2:00 PM until 10:00 PM. Review of the timecard documentation for NA #9 revealed a punch in on 3/29/26 at 4:00 PM and out at 10:15 PM. Review of the facility investigation documentation revealed a Corrective Action Form, dated 4/2/26, for Nurse #6 due to Did not intervene when GNA [geriatric nursing assistant] was verbally inappropriate to a resident in a timely manner.Review of a 3/30/26 progress note written by the Director of Nursing (DON) revealed: .The ADON [Assistant Director of Nursing] and I spoke to [name of Resident #21] this AM and s/he denies that the GNA or s/he had used foul language but that the GNA did raise her voice, slam the door and his/her feelings were hurt.On 4/1/26 Nurse #8 wrote: Resident had periods<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | of crying during evening shift. When asked what's wrong, [s/he] stated that an aide from a couple of days ago yelled at [him/her] and cussed [him/her] out. When asked if [s/he] reported this incident, [s/he] stated that, yes, [s/he] did.On 4/1/26 Social Worker #4 wrote: This writer met with [name of Resident #21] on 3/30 and again on 3/31/26 to assess psychosocial well being and discuss concerns stemming from verbal abuse allegation. [Resident name] presented as tearful; anxious; and stated [his/her] feelings are hurt as [s/he] never expected something like that to happen with that particular staff member, whom [s/he] felt was [his/her] friend. [resident name] reports [s/he] was up at 5am Monday night until Tues morning thinking about what happened, and what [s/he] could do to fix the situation.Review of the 4/2/26 Facility Reported Incident (FRI) Follow-Up Investigation Report Form for FRI # 2967650 revealed a verified allegation of verbal abuse. This form included the following statement: All parties indicate that [NA #9] was very loud when speaking to resident and spoke to [him/her] in an inappropriate manner. NA #9 was terminated from employment and a complaint was filed with the board of nursing.On 5/11/26 at 10:52 AM when asked about abuse, Resident #21 reported: I am legally blind, so an incident happened. I activated my call bell, and this staff member, who had been my friend, came to answer it. She said, F you, and the other staff heard her, and she got reported. I was concerned about my safety if she returned to work, so I was okay when she got fired because I feel safe here.On 5/15/26 at 10:44 AM surveyor reviewed with Director of Nursing and the Nursing Home Administrator (NHA) the concerns regarding the failure to ensure the resident was free from abuse, failure to ensure staff reported the abuse in a timely manner to the NHA and that the perpetrator was not removed from resident care prior to the regularly scheduled end of shift. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>Based on record review and staff interview, the facility failed to ensure a resident receiving a as needed (PRN) compounded psychotropic medication had adequate clinical documentation to support administration, including evidence of non-pharmacological interventions prior to use, monitoring for effectiveness and adverse effects, and complete medication order information, for 1(Resident #31) of 1 residents reviewed for unnecessary medications. The findings include:Resident #31 had diagnoses that included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, paranoid schizophrenia, major depressive disorder, aphasia, psychomotor deficit following cerebral infarction, and history of falls.On 5/14/26 at 2:30 PM, a record review revealed Resident #31 had a physician order for a compounded topical medication containing Ativan (lorazepam), Benadryl (diphenhydramine), and Haldol (haloperidol), to be applied topically to the palm side of the wrist twice daily as needed for increased agitation. The physician order did not include documented dosages of the compounded medications, non-pharmacological interventions to attempt prior to administration, or monitoring parameters for effectiveness or adverse effects.On 5/14/26 at 3:15 PM, a review of Resident #31's care plan revealed interventions related to mood and behavior needs, most recently updated 2/8/26, including periods of socially inappropriate behavior, verbal aggression, taking items belonging to others, and refusal of care related to diagnoses including schizophrenia, anxiety, major depressive disorder, anoxic brain damage, and vascular dementia.A review of the electronic Medication Administration Record (eMAR) and nursing progress notes for Resident #31 from 2/1/26 through 5/15/2026 revealed the following:On 2/26/26 at 2:39 AM and 7:31 PM, the compounded psychotropic medication was administered without documented nursing notes indicating non-pharmacological interventions attempted prior to administration or documentation assessing effectiveness following administration.On 3/1/26 at 5:25 AM, the compounded psychotropic medication was administered without a documented nursing assessment, non-pharmacological interventions attempted prior to administration, or follow-up documentation regarding effectiveness.On 3/5/26 at 11:46 PM, the compounded psychotropic medication was administered without a documented nursing assessment, non-pharmacological interventions attempted prior to administration, or follow-up documentation regarding effectiveness.On 5/13/26 at 6:14 PM and again at 6:15 PM, the eMAR reflected administration of the compounded psychotropic medication. Follow-up documentation was entered at 8:28 PM and 8:42 PM. There were no nursing progress notes documenting the resident assessment, prompting administration, non-pharmacological interventions attempted prior to use, clarification regarding whether a discrepancy in administration times occurred, or assessment of medication effectiveness.On 5/15/26 at 11:00 AM, during an interview with the Nursing Home Administrator and Director of Nursing, they acknowledged concerns regarding the lack of documentation related to the administration and monitoring of the compounded psychotropic medication. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, it was determined that the facility failed to ensure that residents who required assistance with Activities of Daily Living (ADLs) received showers. This was evident in one (Resident #20) of three residents reviewed for ADLs. The findings include:The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to collect information on each Resident's strengths and needs. This information informs Resident care planning decisions.On 5/11/26 at 11:55 AM, Resident #20 was observed sitting in a chair by the bedside. The Resident's room had a strong urine-like odor. An interview with Resident #20 at that time indicated that he/she received only one shower per week. A medical record review on 5/12/26 at 12:14 PM included an MDS assessment dated [DATE] for Resident #20. The MDS indicated that Resident #20 required staff assistance with showering. A further review of the shower schedule for the unit where Resident #20 resided showed that Resident #20 was scheduled for 2 showers per week, totaling 8 showers per month. Further review of the nursing assistant's shower documentation for Resident #20 from March 1 to May 12, 2026, was completed. The review revealed that the Resident received 4 showers in March instead of 8, 7 showers in April instead of 9, and 1 shower as of 5/12/26 instead of 3.In an interview on 5/12/26 at 12:42 PM, staff #20, a nursing assistant, reported that nursing assistants were expected to document and report to the nurses whenever a resident refused a shower. Therefore, if Resident #20 refused any showers, it would have been documented. In an interview on 5/12/26 at 1:22 PM, the unit manager (UM) for the third-floor unit stated that she expected every Resident to receive 2 showers per week, and that if any Resident refused, staff were to document the refusal. The interview lacked documentation confirming whether Resident #20 received all his/her scheduled showers or refused any. |

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|---|---|---|---|
| | 215240 | A. Building<br>B. Wing | 05/15/2026 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on interviews, observations, and record review, it was determined that the facility failed to ensure that skin assessments were completed accurately, failed to identify and document significant bruising, failed to implement care plan interventions for skin monitoring, and failed to report injuries to facility administration. This was evident for 1 (Resident #53) of 4 residents investigated for potential abuse (Intake #3013659). The findings include:On 5/11/26 at 10:55 AM, during the initial screening process, the surveyor interviewed Resident #53. The resident was observed to have a bruise on the left elbow. When asked about the injury, Resident #53 stated, staff is rushed and often hurt [them] when [they are] moved. The resident added that there is a toxic level of carelessness in the facility.Resident #53's private duty assistant, Geriatric Nursing Assistant (GNA #22), was present in the room and provided the surveyor with a photograph of the resident's elbow showing significant ecchymosis (black and blue bruising). GNA #22 stated the photograph was taken on 4/17/26 following an incident where the resident was injured while a nurse and another GNA were providing care. GNA #22 confirmed that Resident #53 is frequently bruised during bathing and repositioning.On 5/13/26 at 9:51 AM, the surveyor reviewed Resident #53's weekly skin assessments from April 1st through April 30th. The review revealed zero documentation of bruising. All weekly assessments documented the resident's skin as warm, dry, normal color, with no petechiae, normal skin turgor, and no skin alterations.On 5/13/26 at 5:03 PM, the surveyor interviewed the Nursing Home Administrator (NHA), Director of Nursing (DON), and the Regional Clinical Director (RCD #11). The surveyor inquired if administration was aware of an incident where staff injured the resident's elbow. All administrative staff denied knowledge of the incident.On 5/14/26 at 12:20 PM, the surveyor conducted a second interview with Resident #53. When asked if the elbow injury was reported to anyone, the resident stated that Nurse #23 was aware and that the injury occurred during a shower transfer. Resident #53 stated that Nurse #23 assessed the elbow for bruising immediately after the incident, but the bruising took several hours to develop.During this interview, the surveyor observed a residual bruise on Resident #53's left elbow, as well as a new, localized red area. GNA #22 stated that when skin issues are reported, facility staff dismiss the concerns by stating the resident bruises easily.Resident #53 noted that a care plan meeting was scheduled for 2:00 PM that day, and the resident planned to address the recurring bruising caused by careless handling during care.On 5/14/26 at 3:02 PM, the surveyor reviewed Resident #53's care plan, which directed staff to:-Inspect skin, especially over bony prominences, during bathing and personal care (CNA).-Complete weekly wound observations (Licensed nurse).-Use draw sheets or similar assistive devices for positioning and turning to maintain skin integrity.-Apply a protective foam dressing to the left elbow and change as needed.-Educate the resident and caregivers on causative factors and measures to prevent skin injury.-Monitor, document, and report as needed (PRN) any changes in skin status, including appearance, color, and wound healing.-Perform skin inspections every shift and report abnormal findings.-Use caution during transfers and bed mobility to prevent striking limbs against sharp or hard surfaces.On 5/14/26 at 3:30 PM, the surveyor reviewed the GNA daily skin assessments for Resident #53. The review revealed that staff failed to document the bruise to the resident's left elbow on any daily assessment.On 5/14/26 at 3:48 PM, the surveyor interviewed the NHA and DON regarding the lack of skin assessment documentation. The DON confirmed there was no documentation to support that staff identified or recorded Resident #53's bruising on either daily or weekly skin assessments. The DON verified that the elbow injury should have been captured in the resident's medical record. |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observe each nurse aide's job performance and give regular training.<br><br>Based on record reviews, interviews, and observations, it was determined that the facility failed to ensure that Geriatric Nursing Assistants (GNAs) received annual performance evaluations and that GNAs received the federally required 12 hours of annual education and in-service training. This was evident for 2 (GNA #17 and GNA #18) of 2 reviewed for annual performance evaluations and for 1 (GNA #18) of 3 annual education and in-service records reviewed while performing the staffing task.The findings include:On 5/13/26 at 6:18 PM, the surveyor reviewed employee records and identified that the most recent performance evaluation for GNA #17 was completed on 7/12/24 and the most recent performance evaluation for GNA #18 was completed on 10/9/24. Both evaluations had exceeded one year since completion.Further review revealed that GNA #18 had not completed abuse, Quality Assurance Performance Improvement (QAPI), or compliance training for greater than one year. Additionally, because a performance evaluation had not been completed, the GNA had not received training assignments based on identified performance needs.On 5/14/26 at 9:28 AM, the surveyor interviewed the Human Resources and Payroll Associate (HR #19) regarding the process for ensuring staff receive required education and performance evaluations. HR #19 stated that she is responsible for ensuring staff are assigned classes that are predetermined by corporate.When asked how the facility ensures staff remain current with required training, HR #19 stated that she sends reports to supervisors when staff are behind on training and posts a list in the breakroom identifying staff who are delinquent in required courses. HR #19 showed the surveyor a bulletin board titled Education Station. The surveyor observed a listing of staff that identified the percentage of assigned course completion. The surveyor observed that GNA #18 was listed in red and identified as only 33.33% complete with required courses.HR #19 stated that the Director of Nursing (DON) is responsible for completion of performance evaluations. HR #19 further stated that QAPI training is completed on paper; however, she was unable to provide evidence that GNA #18 had completed QAPI training.On 5/14/26 at 11:11 AM, the surveyor interviewed the Nursing Home Administrator (NHA), who confirmed awareness that GNA #18 was behind on required training and that the facility had identified it was behind on annual GNA performance evaluations and was working to bring them into compliance. The NHA confirmed that training assignments are expected to be based on each GNA's performance evaluation. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>Based on record review and interviews, it was determined that the facility failed to ensure the attending provider documented in the resident's medical record that they reviewed a pharmacist's recommendations and the attending provider's rationale for declining. This was evident for 2 (Resident #5 and Resident #31) of 5 Residents reviewed for unnecessary medications. The findings include: 1)A review of Resident #5's medical record on 5/13/26 at 11:14 AM revealed a pharmacy medication regimen review (MRR) completed on 11/28/25, which recommended discontinuing an antiulcer medication and an omega-3 fish oil medication. Further review of the MRR showed a Physician/Director of Nursing response stating Decline.<br><br>Further review found that Resident #5's attending physician visited the resident on 12/7/25. In his notes, there was a notation, monthly orders and treatment plan reviewed and signed. The review also noted that Resident #5 had another visit with an attending provider on 12/15/25. However, neither provider's note showed that they reviewed Resident #5's MRR, completed on 11/28/25, with recommendations, nor did it document a rationale for declining those recommendations.<br><br>During an interview on 5/13/26 at 12:37 PM, the director of nursing (DON) stated that she received the MRR reports with recommendations via email and typically reviewed them with the attending providers by phone. Afterward, she documented the attending provider's response to the recommendations in the report and signed it herself. The DON reviewed Resident #5's electronic medical record and reported that it lacked supporting documentation showing that the provider reviewed the MRR and the rationale for declining the recommendations.<br><br>2) Resident #31 had diagnoses that included, but were not limited to, dementia and anxiety disorder.<br><br>On 5/12/26 at 1:25 PM, a review of Resident #31's medical record revealed active medication orders, including:<br><br>Buspirone HCl 7.5 mg,<br><br>Depakote 125 mg,<br><br>Rexulti 0.5 mg, and<br><br>Trazodone 100 mg.<br><br>Additional documentation from the prescribing psychiatric provider indicated the resident remained compliant with the medication regimen; however, the medical record lacked a documented clinical rationale supporting continuation of the psychotropic medication regimen without GDR.<br><br>On 5/12/26 at 1:30 PM, a review of pharmacy consultant documentation and the resident's medical record revealed a pharmacist recommendation dated 12/31/25 requesting provider documentation regarding gradual dose reduction for Buspirone HCl 7.5 mg, Depakote 125 mg, Rexulti 0.5 mg, and Trazodone 100 mg. The record contained a provider declination stating no changes at this time; however, the record lacked a documented clinical rationale supporting why a GDR was clinically contraindicated or otherwise not attempted.<br>(continued on next page) |

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|---|---|---|---|
| | 215240 | A. Building<br>B. Wing | 05/15/2026 |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/13/26 at 12:46 PM, during an interview, the Director of Nursing (DON) reviewed with the surveyor the location of psychiatric nurse practitioner documentation and explained the facility's expectation that documentation include clinical rationale supporting why a gradual dose reduction would or would not be indicated for psychotropic medications. There was no evidence that the provider had assessed and documented that rationale.<br><br>Further review of psychiatric provider documentation dated 1/6/26, 3/12/26, and 5/11/26 failed to reveal a documented rationale regarding the continuation of the resident's psychotropic medication regimen without gradual dose reduction.<br><br>On 5/13/26 at 1:00 PM, the DON acknowledged concerns regarding the lack of a documented rationale from the prescribing provider related to the gradual dose reduction for the resident's psychotropic medications. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, interview and record review it was determined that the facility failed to ensure medications were labeled in accordance with currently accepted professional principles and failed to store all medication in locked compartments. This was found to be evident on one of the two nursing units.The findings include:1.On 5/13/26 at 10:54 AM observation of the 3rd floor medication storage room with Nurse #12 revealed two cups sitting on top of the medication cart. One cup contained the outer portion of capsules that had already been opened and the other cup was full of a brownish liquid. Nurse #12 reported the liquid was med pass (a nutritional supplement) in the cup and proceeded to throw out both of the cups. Nurse #12 then unlocked the medication cart and surveyor observed a medicine cup with about 5 medications sitting in the top drawer. There was no label to identify these medications or to identify who they were for. Nurse #12 reported they were for Resident #20 but the resident did not want them and indicated she had offered multiple times. Nurse #12 then proceeded to throw out the medications and denied that any were narcotics.On 5/13/26 at 11:50 AM review of the Medication Administration Record for Resident #20 revealed Nurse #12 had documented documented that the Med Pass was administered as ordered at 9:00 AM. The nurse had also documented, at 9:57 AM, that the resident had refused the seven medications that were due to be administered by mouth at 9:00 AM. 2. On 5/13/26 review of previously provided documentation from the facility in regard to medication storage areas revealed medications were stored in a nursing supply room on the first floor.On 5/13/26 at approximately 11:00 AM when surveyor asked the corporate nurse #11 about a nursing supply room on the first floor she indicated she was not aware of one. Surveyor and corporate nurse then asked the Nursing Home Administrator (NHA) who reported no medications were stored on the first floor but that some over the counter (OTC) medications were stored in the Assistant Director of Nursing's (ADON) office in a cabinet.On 5/13/26 at 11:10 AM observation, with corporate nurse #11, revealed the ADON's office was located on the third floor across from the nursing station. The office door was not locked. There was a metal cabinet, approximately 5.5 feet in height, located in the ADON's office. There was a metal latch holding the door shut which was able to be unlatched by hand. There was a key hole in the handle of the door but surveyor and corporate nurse were able to open the cabinet without a key. The cabinet contained multiple OTC medications including but not limited to: aspirin; Senna (laxative/stool softner); bottles of liquid iron; Pepcid; cough drops; milk of magnesium; and suppositories.Review of a list provided by the facility revealed more than 20 of the resident's on the third floor have a diagnosis of dementia.On 5/15/26 at 10:44 AM surveyor reviewed with Director of Nursing (DON) and NHA the concerns regarding the failure to ensure medications kept in the medication cart were labeled and failure to ensure OTC meds were kept in a locked area. The DON reported there was now a lock on the cabinet. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>Based on interviews, observations, and record review, the facility failed to implement and maintain an effective Quality Assurance and Performance Improvement (QAPI) program for its water management and Legionella mitigation processes. These failures could affect all residents of the facility who may be exposed to the facility's water system.The findings include:Legionella is a waterborne bacteria associated with respiratory illness and pneumonia-like infections, particularly in vulnerable populations residing in healthcare facilities.On 5/13/26 at 11:40 AM, an interview was conducted with Staff #14, the Maintenance Director, regarding the facility's water management and Legionella prevention processes. Staff #14 stated that maintenance requests are primarily verbal, acknowledged that only limited staff utilize the facility's electronic tracking system, and confirmed that routine shower flushing was not consistently performed or documented. Staff #14 stated that resident room showers were generally not utilized and reported that no routine flushing log was maintained for those showers. Staff #14 also confirmed awareness that the facility had previously experienced Legionella concerns.On 5/13/26 at 11:52 AM, Staff #14 further stated that showers in resident rooms were not routinely flushed unless an odor complaint was received, and acknowledged that there was no documentation log to verify flushing practices. Staff #14 confirmed that some showers containing stored resident belongings would not be flushed.On 5/13/26 at 12:10 PM, Staff #15, the Environmental Services Director, expressed uncertainty about water flushing logs and stated he had only recently been informed that staff were supposed to flush sinks daily. During the same interview, Staff #16, Housekeeping Staff, stated that staff were expected to run water in rooms daily for approximately 10 minutes and reported that they completed the logs submitted monthly. Staff #16 further stated that not all resident room showers were flushed and acknowledged some showers were non-functional.On 5/13/26 at 12:17 PM, Staff #14 acknowledged flushing logs existed but had not initially been provided during the survey process.On 5/13/26 at 12:24 PM, the Nursing Home Administrator (NHA) confirmed awareness of prior Legionella concerns within the facility occurring in December 2025 and acknowledged a second Legionella-related concern had occurred thereafter. The NHA stated that all resident room showers, except one, had been turned off, but was unable to confirm whether showers were routinely flushed.On 5/13/26 between 12:38 PM and 12:47 PM, surveyors observed inconsistent conditions in resident room showers, including some showers running, others off, and dust accumulation on fixtures, indicating a lack of regular use. Residents interviewed stated they received showers in hallway bathing rooms rather than in their resident rooms.On 5/13/26 at 3:09 PM, Staff #3, the Infection Preventionist, stated that the facility only tested residents diagnosed with pneumonia for Legionella, despite guidance directing testing of residents with respiratory illness symptoms. Staff #3 stated that she believed the guidance applied only to residents diagnosed with pneumonia.On 5/13/26 at 3:40 PM, Staff #11, Regional Director of Clinical Operations, and the NHA acknowledged concerns related to Legionella mitigation practices, flushing documentation, and failure to follow guidance regarding resident testing for Legionella-associated respiratory symptoms.On 5/13/26 at 4:15 PM, the surveyor reviewed email guidance from the Allegany County Health Department with Staff #3 dated 1/8/26, which directed the facility to test residents with pneumonia-like or respiratory symptoms for Legionella. Staff #3 acknowledged she had misinterpreted the guidance.On 5/13/26 at 4:22 PM, Staff #14 confirmed there was no comprehensive log identifying which showers were active or shut off and acknowledged there was no routine flushing process for resident room showers. Review of housekeeping flushing checklists revealed flushing documentation was incomplete, inconsistently performed, lacked complete dates and staff identifiers, and did not demonstrate daily flushing practices as identified in the facility's water management plan.During the same interview, Staff #14 acknowledged ongoing concerns about water temperatures and stated that they frequently required several minutes of run time before reaching approximately<br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 100 degrees Fahrenheit.On 5/14/26 at 9:54 AM, the survey team identified ongoing systemic concerns regarding water temperatures and the implementation of the facility's Legionella prevention and water management program. The review indicated that the facility had previously identified Legionella concerns during the 2025 annual survey and had submitted a plan of correction outlining monitoring and mitigation measures.On 5/14/26 at 11:55 AM, Staff #11 stated the Legionella concerns should have been addressed through the facility's Quality Assurance and Performance Improvement (QAPI) process, but was unable to confirm or provide evidence that the issue had been formally incorporated into the facility's QAPI program prior to the start of the annual recertification survey.Guidance from the Allegany County Health Department on 1/8/26 and the facility's water management resources directed the facility to test residents with respiratory illness symptoms for potential Legionella infection.On 5/15/26 at 11:00 AM, the NHA and Director of Nursing confirmed concerns existed regarding the facility's water management and Legionella mitigation processes. They further confirmed that the facility had not implemented a formal testing protocol or an ongoing data collection process for respiratory illness surveillance or Legionella mitigation efforts prior to the start of the annual recertification survey.Refer also to F880. |

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| F 0923<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have enough outside ventilation via a window or mechanical ventilation, or both.<br><br>Based on observation and interview with facility staff, it was determined that the facility failed to ensure proper airflow in the soiled laundry rooms. This was evident from the tours of the soiled laundry rooms conducted during the annual survey.The findings include:Airborne transmission occurs when pathogens are so small that they can be easily spread in the air, and because of this, there is a risk of transmitting the disease through inhalation. These small particles containing infectious agents may be spread over long distances by air currents and may be inhaled by individuals who have not had face-to-face contact with (or been in the same room with) the infectious individuals. According to the Centers for Disease Control and Prevention (CDC), preventing the spread of pathogens that are transmitted by the airborne route requires the use of special air handling and ventilation systems. On 05/12/2026 at 11:00 AM, the surveyor conducted a tour of the clean and soiled laundry rooms alongside the Healthcare Services Group Environmental Services Director. During the tour, a strong odor was noted in the soiled laundry rooms due to absence of negative pressure airflow from the mechanically operated ventilation systems serving the two soiled laundry rooms. At 3:00 PM, a follow-up tour of the laundry rooms was conducted with the Maintenance Director. During the tour, it was observed that a window in one of the soiled laundry rooms was open to provide air circulation. An interview with the Maintenance Director revealed that the roof exhaust fans would be reassessed to ensure proper airflow from the mechanically operated ventilation systems. |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.<br><br>Based on record reviews, interviews, and observations, it was determined that the facility failed to ensure that Geriatric Nursing Assistants (GNAs) received education based on annual performance evaluations and that GNAs received the federally required 12 hours of annual education and in-service training. This was evident for 2 (GNA #17 and GNA #18) of 2 reviewed for annual education while performing the staffing task.The findings include:On 5/13/26 at 6:18 PM, the surveyor reviewed employee records and identified that the most recent performance evaluation for GNA #17 was completed on 7/12/24 and the most recent performance evaluation for GNA #18 was completed on 10/9/24. Both evaluations had exceeded one year since completion.Further review of GNA #18's education training record revealed that GNA #18 had only completed 9.5 hours of training over the past year. Additionally, because a performance evaluation had not been completed, the GNA's (#17 and #18) had not received training assignments based on identified performance needs.On 5/14/26 at 9:28 AM, the surveyor interviewed the Human Resources and Payroll Associate (HR #19) regarding the process for ensuring staff receive required education and performance evaluations. HR #19 stated that she is responsible for ensuring staff are assigned classes that are predetermined by corporate.When asked how the facility ensures staff remain current with required training, HR #19 stated that she sends reports to supervisors when staff are behind on training and posts a list in the breakroom identifying staff who are delinquent in required courses. HR #19 showed the surveyor a bulletin board titled Education Station. The surveyor observed a list of staff that identified the percentage of assigned course completion. The surveyor observed that GNA #18 was listed in red and identified as only 33.33% complete with required courses. HR #19 confirmed that GNA #18 was behind on her annual training.On 5/14/26 at 11:11 AM, the surveyor interviewed the Nursing Home Administrator (NHA), who confirmed awareness that GNA #18 was behind on required training and that the facility had identified it was behind on annual GNA performance evaluations and was working to bring them into compliance. The NHA confirmed that training assignments are expected to be based on each GNA's performance evaluation.Cross Reference F730 |