STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215043	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Turtle Creek Rehabilitation and Wellness Center	3000 McComas Avenue Kensington, MD 20895

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined that the facility failed 1) failed to review and revise a resident's care plan, and 2) to ensure interdisciplinary care plan meetings were held to address residents' care needs after the completion of the Minimum Data Set assessment. This was found to be evident for 1) one resident (Resident #6) of five reviewed for advance directives, and 2) two residents (Resident #108 and #51) of four residents reviewed for neglect. The findings include:1). MOLST stands for Medical Orders for Life-Sustaining Treatment. It is an actionable medical document used for patients with serious, advanced illnesses to stipulate specific preferences for end-of-life care—such as intubation, resuscitation, and feeding tubes—that are recognized across various healthcare settings, including hospitals, nursing homes, and emergency care. A review of Resident #6's medical records was conducted on [DATE] at 12:09 AM. The review revealed that the resident's most recent MOLST form which was dated [DATE], indicated to attempt cardiopulmonary resuscitation (CPR) if cardiac and/or pulmonary arrest occurs. However, Resident #6's care plan initiated on [DATE] and revised on [DATE], indicated the resident's code status as do not resuscitate (DNR) as it was related to his/her MOLST. Also, a review of the resident's current medical record revealed an active DNR order dated [DATE]. The nurse (Nurse #14) who was currently assigned to Resident #6 care was interviewed on [DATE] at 1:42 PM. During the interview, Nurse #14 confirmed that Resident #6 had conflicting information regarding code status and when asked what she would do if the resident's heart stopped, she answered, I wouldn't provide CPR and indicated that her decision was based on the resident's current care plan and medical orders. Nurse #14 then reported that she would discuss the finding with the Nurse Practitioner (Staff #15). The surveyor accompanied Nurse #14 to discuss the findings with Staff #15 on [DATE] at 1:56 PM. Staff #15 reported that the resident was full code and had the capacity to make medical decisions. She also confirmed the finding of conflicting information regarding the resident's code status and reported that the Social Worker should have updated Resident #6's medical record when the MOLST was changed. A subsequent review of Resident #6's medical record was conducted on [DATE] at 2:32 PM. The review revealed a note from the social worker (Staff #4) that indicated the most recent care plan meeting/conference was held on [DATE] at 2:15 PM where the code status was reviewed and indicated as a DNR. On [DATE] at 9:49 AM, the Director of Nursing (DON) was interviewed and reported that she was (continued on next page)

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	already aware of the concern with Resident #6's conflicting code status information and that an audit was started to review medical records of random residents to ensure they are updated and accurate. Resident #6's medical record was reviewed with the DON and revealed that the current care plan still indicated DNR. The DON then updated the care plan and acknowledged that it should have been reviewed and updated on [DATE] when the new MOLST was done. 2.a) The Minimum Data Set (MDS) is a federally mandated assessment that nursing home staff use to collect information about each Resident's strengths and needs. This information is then used to make care planning decisions for the Resident. Maryland state regulations require the nursing home to hold the care planning conference not later than 7 calendar days after completing the assessment but may hold the conference sooner if agreed to by the resident, a family member, or a resident's representative. On [DATE] at 12:20 PM an interview with Social Worker #4 revealed that she had identified an issue with failure to have care plan meetings when they were due and had initiated a quality assurance/performance improvement plan in either December or January. On [DATE] a review of Resident #108's electronic health record revealed that an MDS assessment was completed in November, and a Care Conference Note revealed a meeting took place on [DATE]. Further review of the medical record revealed an MDS assessment with an assessment reference date (ARD) of [DATE] but no Care Conference Note was found to indicate a meeting had occurred after the [DATE] assessment. On [DATE] at 4:35 PM the surveyor reviewed with the Director of Nursing the concern that the facility failed to have a care plan meeting after the [DATE] MDS assessment. 2.b) A review of Resident #51's medical records was conducted on [DATE] at 11:51 AM. The review revealed that a quarterly assessment was completed on [DATE]. However, the last care conference note had an effective date of [DATE] created by the Social Worker (Staff #4). In an interview with Staff #4 on [DATE] at 11:57 AM, she reported that care plan meetings are held on Wednesdays and Thursdays and that her timeframe was to have one within 7 days prior to and 7 days after the resident's ARD of comprehensive and quarterly assessments. Staff #4 confirmed that her understanding of the regulation with regards to care plan meetings was that she had 7 days before or after the MDS ARD dates. A review of Resident #51's medical record was conducted with Staff #4 on [DATE] at 12:06 PM. She confirmed the resident's most recent MDS assessment had an ARD of [DATE]. Staff #4 was asked if she had or scheduled a care plan meeting based on that MDS assessment. She reported that she met with the resident's guardian on [DATE] and wrote a progress note about it but did not write it as a care conference note. She also reported that she was trying to schedule a care plan meeting with the guardian, however he could not make that date and she stated, I need to have the guardian present for the care plan meeting. Further review of Resident #51's medical record with Staff #4 revealed the progress note she wrote on [DATE] that described her talking to the resident regarding a concern with his/her behavior. There was no indication on the note that the guardian was present nor was there any indication that the resident's care plan was reviewed and/or discussed. The concern was discussed with Staff #4 that (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the regulation does not require the residents, guardian and family members to attend the care plan meeting, however the facility is still required to hold a care plan meeting within 7 days after a comprehensive or quarterly MDS assessment is completed. Staff #4 verbalized understanding and acknowledged the concern.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on record reviews, interviews, and observations, it was determined that the facility failed to provide activities based on the resident's comprehensive assessment. This was evident for 1 (Resident #51) of 4 residents reviewed for neglect. The findings include:The concerns related to Complaint2795585 included a report that staff was mistreating Resident #51 by showing other residents more attention. On 4/14/26 at 10:08 AM, Resident #51 was observed in room, watching TV.On 4/17/26 at 12:10 PM, a review of Resident #51's most recent comprehensive assessment with a reference date of 7/15/25 section F, indicated that it was very important for the resident to do things with groups of people and to go outside to get fresh air when the weather is good.On 4/17/26 at 12:15 PM, Resident #51's care plan for activities included interventions such as, encouraging attendance to entertainment programs, large and small group activities, volunteer demonstrations, and religious activities; and invite resident to scheduled activities.A review of April 2026 activities and activity participation was conducted on 4/17/26 at 12:17 AM. The review failed to show documentation that the resident attended or was offered and refused to attend group and/or outdoor activities.The Activity Director (Staff #7) was interviewed on 4/17/26 at 12:22 PM. During the interview, Staff #7 reported that Resident #51 usually prefers to do independent activities in his/her room. Staff #7 was asked if he or activity staff document the refusal when group and outdoor activities are offered to the resident. He reported that refusals are documented and group activities are done daily. A review of Resident #51's medical record was conducted with Staff #7, and he confirmed that there was no documentation to indicate that the resident had attended or refused to attend group and/or outdoor activity for April and March 2026. The concern was discussed with Staff #7 that the facility failed to provide activities to the resident based on the comprehensive assessment and individualized care plan. Staff #7 verbalized understanding and acknowledged the concern.