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	06/10/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interviews, it was determined the facility staff failed to notify the practitioner when a resident was assessed to have extremely high blood glucose levels. This was evident for 1 (#2) of 2 residents reviewed for neglect.The findings include:Finger stick blood sugar (BS) readings are obtained from a small drop of blood from a poke to a finger. The American Diabetes Association and Centers for Disease Control (CDC) suggest the recommended pre-meal blood glucose (sugar) readings should range between 80-130 mg/dL and less than 180 mg/dL 1-2 hours after the beginning of a meal; Target ranges may be different based on age, health status and diabetes management plan; Follow physician recommendations specific to each individual. However, results above 600 mg/dL are considered a life-threatening medical emergency. Complaint #3201771 and Resident #2's medical record were reviewed on 6/8/26 at 1:00 PM.The medical record revealed physicians orders written on 5/9/26 for finger stick blood sugar (BS) testing before meals and at bedtime. Resident #2's May and June Medication Administration Record's (MAR) included documentation of the resident's BS readings from 5/9/26 to 6/8/26.On 5/11/26 Licensed Practical Nurse (LPN) #9 documented at 4:30 PM and 9:00 PM Resident #2's BS levels were 515, on 5/13/26 at 9:00 PM she documented 524. On 5/14/26 at 6:30 AM LPN #10 documented Resident #2's BS was 524. Further review of the medical record failed to reveal the nurses notified the physician or on call provider of Resident #2's extremely high blood sugar test results. On 6/10/26 at 8:30 AM the surveyor asked Medical Records Director #5 to provide documentation reflecting the provider notification of Resident #2's high finger stick BS levels. None was provided.At that time, the Regional Director of Clinical Services #3 provided a copy of Resident #2's MAR for May 2026 and indicated that a physician order to notify the provider of finger stick BS levels higher than 400 was not written until 5/13/26. When asked if she would expect a licensed nurse to recognize the significance of extremely high blood sugar levels and call a provider in the absence of an order, she indicated that she would. She was made aware of the above findings and the 0630 BS level on 5/14/26 was obtained after the physician order was written on 5/13/26. In an interview on 6/10/26 at 3:19 PM LPN #9 was asked what she did after identifying extremely high finger stick blood sugar results. She indicated that she should call the doctor and recheck it again. She indicated that she was informed earlier that she didn't document the rechecked blood sugar levels.She was made aware that she documented Resident #2's extremely high blood sugar levels on the MAR However, no repeat BS levels or notification of the provider were documented. When asked if there was a reason she didn't notify the provider, she indicated that she was a new nurse and is still learning the policies. When asked if she was familiar with the standards of nursing practice, she indicated again that she is a new nurse and that she should have called the provider when the resident's blood sugar was higher than 400. The above concerns were reviewed with the [NAME] President of Clinical Operations on 6/10/26 at approximately 3:45 PM.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of facility reported incident investigations and staff interview it was determined that the facility failed to thoroughly investigate allegations of neglect. This was evident for 1 (#4) of 2 residents for neglect.The findings include: On 6/10/26 at 9:35 AM, a review of the facility's investigation file for the self-report 2964230, which alleged Resident #4 was left to feed him/herself with the door closed, spilling food on him/herself, was conducted. The self-report indicated the alleged incident occurred on 3/7/26 and was reported to the facility on 3/25/26. The Facility Reported Incident Follow-Up Investigation Report Form documented a skin assessment was completed on Resident #4, who was non-verbal, and other non-interviewable residents and interviewable resident were interviewed. Continued review of the documents included with the facility's investigation found no evidence that interviews had been conducted with interviewable residents and there was no evidence skin assessments had been completed with any non-interviewable residents. On 6/10/26 at 11:13 AM, during an interview, the Nursing Home Administrator (NHA) was made aware that no resident interviews and no skin assessments of non-verbal residents were found with the facility's investigation documents provided to the surveyor. The NHA acknowledged the concern and stated he would look for the documents. On 6/10/26 at approximately 3:45, PM, [NAME] President of Clinical Operations (Clinical VP) was informed the facility's investigation failed to include evidence of resident interviews and skin assessments of non-interviewable residents. The Clinical VP acknowledged the concerns and stated she would have the NHA speak to the surveyor. On 6/10/26 at 3:58 PM, the concern with failing to thoroughly investigate the above allegation of neglect was discussed with the NHA and Clinical VP. At that time, the NHA acknowledged the concerns and stated he was still looking for the documentation to indicate residents were interviewed and skin assessments of non-interviewable residents had been conducted. As of time of exit from the survey, on 6/10/26 at approximately 5:00 PM, no documentation of resident interviews and no skin assessments of non-interviewable residents was provided to the surveyor.