STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215355	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Encore at Turf Valley	11150 Resort Road Ellicott City, MD 21042

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 2. During observation rounds on 5/8/25 at 9:00 AM, Resident #18 was observed lying in bed near the window, with the bed in its lowest position. The resident was uncovered with a brief exposed; the resident's curtain was open and the resident could be seen from the hallway by staff or visitors. The resident was yelling to help get to their tray. The resident tray was located on the bedside table and the bedside table was observed pushed against the wall in a high position. The resident stated my tray is often left on the table and not given to me when my meals are served. This surveyor informed the Licensed Practical Nurse (LPN #11) of the observation on 5/8/25 at 9:10am. She stated the tray should not have been left in the room without setting the tray up for the resident and she would take care of it. Based on observation, interview, and record review, it was determined that the facility failed to promote care in a manner that maintains dignity and respect and failed to ensure that meal trays were appropriately presented to residents requiring assistance. This deficient practice was evident for 2 of 15 residents reviewed (Residents #18 and #29) during the survey. The findings include: 1. During the surveyor's initial tour of the facility on 5/8/25 at 8:32AM the surveyor observed Resident #29 lying in their bed awake and reaching their arms in an upward motion. Resident #29's tray holding their breakfast meal and water cup was observed by the surveyor sitting on their nightstand furniture. No staff were observed present within the resident's room. Review of the medical record by the surveyor on 5/13/25 at 12:41PM revealed assessment documentation of the resident's eating habits on the Resident Summary V2 form dated 5/1/25 which indicated the resident required assistance from staff and was dependent on staff for eating. Review of the medical record of Resident #29 by the surveyor on 5/13/25 at 1:38PM revealed a nutrition note dated 5/12/25 which documented the following information: S/he is encouraged and assisted by staff at mealtimes, feel current interventions remain appropriate. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 10:46AM the surveyor conducted an interview and shared the concern with the facility's Director of Nursing (DON) who acknowledged and confirmed understanding of the surveyor's concern. During the interview the DON acknowledged that staff had passed the trays prior to providing feeding assistance to residents who required it on 5/8/25 and after intervention by the survey team they had provided education to staff regarding the procedure for passing resident meal trays and feeding assistance. On 5/14/25 at 1:41PM the surveyor reviewed the facility's policy for feeding residents which was observed to include the following information: Hold resident tray on cart to maintain temperature until the end of tray pass or until ready to assist with feeding. On 5/14/25 at 2:00PM the concern was reviewed with the DON and the Administrator during the facility's exit conference.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and an interview, it was determined that the facility failed to ensure that residents were provided written information regarding their right to formulate an advance directive upon admission This was evident for 2 (Residents #13, #62) out of 6 residents reviewed for Advance Directives. The findings include: According to the Centers for Medicare and Medicaid (CMS) the definition of an Advance Directive is a document that appoints an agent and records a patient's medical treatment wishes based on their values and preferences. Advance Directives can be different from state to state. On 05/08/2025 at 1:13 PM, a review of the electronic medical records for Residents #13 and #62 revealed no documentation of advance directives or evidence that the residents had been provided with information about their rights to establish one at the time of admission. At that time, the surveyor requested the Director of Nursing (DON) assist in locating any documentation related to the advance directive discussions or provision of information. On 05/12/25 at 08:05 AM, the DON brought documentation of contact with the two residents' responsible parties. The request for Resident #13's advance directive was dated 05/08/24 at 08:54 PM and Resident #62's responsible party was contacted on 05/09/25 at 3:22 PM. During an interview on 05/14/25 at 12:29 PM, the DON stated that the facility's process for handling advance directives includes requesting the information at admission, followed by contacting the resident's family to locate and provide the documents. On 05/14/25 at 1:15 PM, the DON provided a progress note dated 03/28/25, which stated: Social work addressed status of advance directives for health. However, the facility was unable to provide any signed documentation verifying that information about advance directives was presented to the resident upon admission, or at any other point thereafter.

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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 interview and record review it was determined the facility failed to notify the physician of a resident's change in condition in a timely manner. This was evident for 1 (Resident #83) out of 1 resident reviewed for neglect during the survey. The findings include: On 5/8/25 at 8:30AM the surveyor requested the medical record of Resident #83 from the facility's Director of Nursing (DON) after review of complaint MD00204946. Review of the medical record by the surveyor on 5/9/25 at 2:31PM revealed documentation of Resident #83's blood pressure reading of 88/52 on 4/6/24 at 8:51PM. On 5/9/25 at 2:31PM the surveyor requested from the facility's DON, all documentation of notification to Resident #83's physician of the blood pressure reading of 88/52. On 5/13/25 at 9:44AM the surveyor reviewed the e-medical notification message provided by the DON which was dated 4/6/24 at 9:13PM from Licensed Practical Nurse (LPN) #15 to Physician #16 which revealed Resident #83 had the following vital signs at 5:00PM on 4/6/24: blood pressure of 74/42, pulse of 52, O2 of 92, and by 5:30PM on 4/6/24 they had a blood pressure of 88/52, and at 8:00PM on 4/6/24 they had a blood pressure of 68/42 and a pulse of 99 and 2 liters of oxygen was in place and medication was held by the nurse. The surveyor noted that the initial vital sign changes documented by LPN #15 as beginning at 5:00PM were not communicated to Physician #16 until approximately 4 hours and 13 minutes after the changes began, at which time Physician #16 then provided a response on 4/6/24 at 9:34PM. On 5/14/25 at 8:35AM surveyors provided an opportunity for the DON to provide any and all further documentation that the physician was notified of the vital sign changes of the resident prior to 9:13PM on 4/6/24. In response to the surveyor's request, the DON stated the following information to surveyors: I don't know if the physician was in the building and it was an fyi (for your information) to the nurse from the physician. When the surveyor inquired to the DON as to if communication regarding the resident's medical status should be documented in the resident's medical record, they responded: Yes. On 5/14/25 at 8:45AM the surveyor conducted an interview with the DON who reported to surveyors that there was no documentation of notification of the resident's condition change to the physician prior to 9:13PM on 4/6/24. On 5/14/25 at 10:46AM the surveyor shared the concern with the DON who acknowledged and confirmed understanding of the concern. On 5/14/25 at 2:00PM the concern was reviewed with the DON and the Administrator during the facility's exit conference.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and staff interview, it was determined that the facility failed to ensure the confidentiality of resident records by allowing protected health information (PHI) to remain visible on an unattended computer screen at the main nursing station. This failure resulted in unauthorized exposure of resident names, insurance payor information, and care levels for 27 residents. The findings include: On 05/08/25 at 8:45 AM, an observation was made of an unattended computer screen at the main nursing station displaying protected health information (PHI). The screen was clearly visible to anyone passing by, and it listed the names of 27 residents, along with their insurance payor information and care level. The screen faced an area that visitors and residents can access and from which the information would be readable. No staff member was present at the station during the observation. On 05/13/25 at 12:47 PM, an interview was conducted with the Director of Nursing (DON), who confirmed that PHI should not be left visible or accessible when unattended. The DON acknowledged that the screen should have been locked or turned off to prevent unauthorized viewing and affirmed that the information displayed constituted PHI.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview with facility staff, it was determined that the facility failed to timely report allegations of abuse within the required two-hour timeframe to the Survey Agency, the Office of Health Care Quality (OHCQ). This was evident for 1 (MD00199783) of 2 facility related incident reports reviewed during the survey. The findings include: On 05/12/25 at 9:53 AM, it was determined that the facility failed to report an allegation of abuse in a timely manner for Resident #13. The incident was reported to the facility on [DATE] at 2:00 PM but was not submitted to the Office of Health Care Quality (OHCQ) until 11/21/23 at 10:00 AM, exceeding the required reporting timeframe of within 2 hours for allegations of abuse. During an interview on 05/13/2025 at 12:45 PM, the Director of Nursing stated that the facility's policy and expectation is that all abuse allegations are to be reported within two hours of being made known to staff. This confirmed that the reporting of the allegation involving Resident #13 was not in accordance with this expectation.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on observation, medical record review and staff interview, the facility failed to ensure a resident receives the correct diet as ordered by the physician. This was evident for 1 (Resident #133) of 23 residents observed during the survey. The findings include: On 5/8/25 at 08:30 AM, an initial observation of Resident #133 revealed the resident had the wrong breakfast tray delivered to his/her room. A Review of the meal ticket located on the tray revealed the tray belonged to Resident #74. On 5/8/25 at 8:35am the GNA (Geriatric Nursing Assistant) staff #10 entered the room carrying another tray for Resident #133. When asked about the tray that was already delivered to the resident he stated, I don't know who brought the other tray into this room, but this has the resident name on it. Staff #10 removed the incorrect tray. The LPN (Licensed Practical Nurse) staff #11 were made aware of the findings, she stated an agency GNA put the tray in the resident room in error. On 5/8/25 at 10:21 AM, Resident #133's medical record revealed a physician order for a regular diet. A Review of Resident #74's medical record revealed a physician order for a Dysphagia Level 2 diet, also known as the Dysphagia Mechanically Altered diet, focuses on moist, soft -textured foods that are easy to chew and swallow. On 5/9/25 during an interview with the DON (Director of Nursing) she stated staff #11 made her aware of the incident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews with facility staff, it was determined the facility failed to ensure that foods that were stored in the refrigerator and freezer had a date when prepared and opened. This was found to be evident during an initial tour of the kitchen during the survey. The findings include: An initial tour of the kitchen was conducted on 5/8/25 at 8:30 AM with the Dietary Manager (#6) and Kitchen Supervisor (#5) present and the following concerns were identified. Further observations were made of the stored refrigerator foods, and the following items were identified: 6 large silver trays of French fries with no date on it. 5 large silver trays of biscuits with no date on it 2 large silver trays of turkey sausage with no date on it 28 large silver trays of bacon with no date on it 1 (2 lb) bag of Pepper jack cheese cubes opened with no date when opened 1 (2 lb) bag of Swiss cheese cubes opened with no date when opened. Inside the Freezer there was a large silver tray with 4 frozen fruit pies with no date on it and a 1/2 bag of frozen biscuits with no date when it is opened. The DON was made aware of all concerns on 5/8/25 at 11:45 AM. All concerns were discussed with the Administration team at the exit conference on 5/14/25 at 2:30PM

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review it was determined the facility failed to ensure accuracy of medical assessment documentation of a resident. This was evident for 1 (Resident #38) out 3 residents reviewed for pressure ulcer/injury during the survey. The findings include: On 5/8/25 at 2:26PM the surveyor conducted a review of the medical record for Resident #38 which revealed skilled progress note documentation on 2/1/25 of the resident's skin integrity by Licensed Practical Nurse #13 which indicated the resident had sacrum wounds. On 5/13/25 at 2:35PM the surveyor reviewed the February 2025 Treatment Administration Record (TAR) which documented weekly skin assessments performed by various nursing staff indicating the resident's skin was intact. Further review of the February 2025 TAR by the surveyor on 5/13/25 at 2:37PM revealed additional skin assessments performed twice weekly by various nursing staff on the resident's shower days which indicated the resident's skin was intact. No change of condition or additional documentation regarding new or existing sacral wounds could be found within the resident's medical record. On 5/14/25 at 10:28AM the surveyor conducted an interview of the facility's Assistant Director of Nursing (ADON) who confirmed with the surveyor that Resident #38 did not have any sacral wounds. The surveyor shared their concern with the ADON who stated they would review the resident's medical record. On 5/14/25 at 10:31AM the surveyor conducted an interview with Registered Nurse (RN) #14 who was assigned care of Resident #38. During the interview RN #14 confirmed they had performed skin assessment of the resident and their skin was intact with no concerns. On 5/14/25 at 11:49AM the ADON approached the surveyor to inform that Resident #38 did not have any sacral ulcers/concerns and the 2/1/25 documentation was incorrectly documented and would be corrected. On 5/14/25 at 12:30PM the surveyor shared the concern with the Director of Nursing (DON) who acknowledged and confirmed understanding of the concern and stated the following information to the surveyor regarding the 2/1/25 documentation: It should be striked [sic] out, it was in the wrong chart. On 5/14/25 at 2:00PM the concern was reviewed with the DON and the Administrator during the facility's exit conference.

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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. Based on observations and interviews with facility staff it was determined the facility failed to adhere to infection control practices and procedures to prevent the transmission of dirt and germs when storing dish trays in the kitchen. This was found to be evident during observations made in the kitchen during the survey. The findings include: An initial tour of the kitchen was conducted on 5/8/25 at 8:30AM with the Dietary Manager (# 6) and Kitchen Supervisor (5) present and the following concerns were identified: Dish Crates observed on the floor next to the Dishwasher, across from the Dishwasher and stored on the floor. There were greater than 10 crates stored on the floor. The surveyor asked if dish crates are to be stored on the floor and the DM stated, no. At this time, he picked up all the trays and ran them through the dishwasher to clean them. The DON was made aware of all concerns on 5/8/25 at 11:45 AM. All concerns were discussed with the Administration team at the exit conference on 5/14/25 at 2:30PM