

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2025
NAME OF PROVIDER OR SUPPLIER Ellicott City Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 North Ridge Road Ellicott City, MD 21043	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on interview, record review, facility document review, and facility policy review, the facility failed to immediately inform the resident's legal representative of an accident involving 1 (Resident #9) of 3 residents reviewed for notification of change in condition.</p> <p>Findings included:</p> <p>An undated facility policy titled, Notification of Change in Condition, revealed, The purpose of this policy is to provide guidance for notifications made to residents, resident representatives, and authorized family members for resident changes in condition. Changes may include but are not limited to accidents, incidents, transfers, changes in overall health status, significant medical changes, therapy services changes, transfer, hospitalizations, or death. The policy revealed, Compliance Guidelines: The center must inform the resident, consult with the resident's medical practitioner and/or notify the residents' representative, authorized family member, or legal power of attorney/guardian when there is a change requiring such notification. Circumstances requiring notification including but not limited to: 1. Accidents a. resulting in injury b. potential to require physician intervention.</p> <p>An admission Record revealed the facility admitted Resident #9 on December 2024. According to the admission Record, the resident had a medical history that included unspecified dementia of unspecified severity, adjustment disorder with anxiety, restlessness and agitation, cognitive communication deficit, end stage renal disease, dependence on renal dialysis, mild cognitive impairment of uncertain or unknown etiology, and other symptoms and signs involving cognitive functions and awareness.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/22/2024, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident was independent with rolling left and right in bed, moving from a seated to lying position, and from a lying to seated position on the side of the bed. The MDS indicated Resident #9 required supervision/touching assistance with standing from a seated position, chair/bed-to-chair transfers, and walking 10 feet once standing.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #9's Care Plan Report, included a focus area initiated 12/09/2024, that indicated the resident had a court-appointed guardian and lacked the ability to make health care decisions. The Care Plan Report included a focus area initiated 12/09/2024, that indicated the resident had a mood disorder related to a diagnosis of anxiety. Interventions directed staff to communicate with the resident and the resident's representative regarding mood state and treatment. The Care Plan Report included a focus area initiated 12/07/2024, that indicated the resident had a risk for falls related to muscle weakness and comorbidities.</p> <p>During a telephone interview on 06/18/2025 at 1:10 PM, Guardian #15, Resident #9's guardian, stated when the resident was being taken to dialysis (on the lower floor of the nursing home building) the resident was pushed into the elevator and panicked because the resident was afraid of tight spaces. Guardian #15 said Resident #9 jumped out of the wheelchair onto the floor. Guardian #15 said Resident #9 complained that their knee was hurt; the doctor was notified and ordered an x-ray. Guardian #15 said Resident #9 was sent to the hospital a few days later for swelling and bruising. Guardian #15 stated the facility failed to notify them when the incident happened.</p> <p>An Order Appointing Guardians of the Person and Property, dated 12/06/2024, revealed Resident #9 lacked sufficient understanding or capacity to make or communicate responsible decisions concerning their person and property because of a disability related to delirium and major neurocognitive disorder. The order indicated that the appointed guardian was authorized to give consent for medical or other professional care and necessary protective services.</p> <p>An undated report titled, Resident History Report, revealed a Date Modified, of 12/09/2024 at 1:44 PM, that indicated Resident #9's guardian was added as care conference person, emergency contact #1, and guardian of person. The report specified, All matters involving [patient] is [sic] to be discussed [with] court appointed guardian.</p> <p>A NH [Nursing Home] H&P [History and Physical] Note, dated 12/10/2024, revealed a physician documented Resident #9 had poor insight, severely impaired memory, impaired judgement, and was oriented to self only. The note indicated the resident had a court appointed guardian.</p> <p>An eInteract Change in Condition Evaluation, dated 12/20/2024 at 10:30 AM, revealed Resident #9 was in their wheelchair in the elevator while being escorted to dialysis when they jumped from the wheelchair and fell to the floor in front of the transporter. The evaluation indicated no injuries were noted, but the resident complained of left lower extremity pain, and when notified, a physician ordered an x-ray to the resident's left lower extremity. The evaluation revealed, C. Resident Representative Notification 1. Name of family/resident representative notified: self 2. Date and time of family/resident representative notification: 12/20/2024.</p> <p>During an interview on 06/24/2025 at 1:44 PM, Licensed Practical Nurse (LPN) #3 stated he was assigned to Resident #9 on the day they fell in the elevator, but did not remember why the guardian was not contacted. LPN #3 said he would have checked the admission record and contacted the responsible party listed for the resident.</p> <p>During an interview on 06/26/2025 at 4:48 PM, the Administrator stated he expected a resident's responsible party to be contacted in a reasonable amount of time, and the timeframe depended on the seriousness of the issue.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/27/2025 at 8:13 AM, the Director of Social Services (DSS) stated he expected the staff to look at the admission record to find out who the resident's representative was and notify the person of a change in condition.</p> <p>During an interview on 06/27/2025 at 9:15 AM, the Director of Nursing (DON) stated if a resident had a guardian, she expected staff to identify it on the admission record.</p> <p>During an interview on 06/27/2025 at 11:00 AM, the DSS confirmed the facility's computer system showed Resident #9's admission record was changed on 12/09/2024 to show the resident had a guardian. The SSD stated the resident's responsible party contact information was correct at the time of their fall on 12/20/2024, and he did not know why staff failed to notify the guardian.</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>2. An admission Record revealed the facility admitted Resident #10 on November 2023. According to the admission Record, Resident #10 had a medical history that included a diagnosis of unspecified Alzheimer's disease.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/19/2025, indicated Resident #10 had severe impairment in cognitive skills for daily decision-making and had a short-term and long-term memory problem per a Staff Assessment for Mental Status (SAMS).</p> <p>Resident #10's Care Plan Report included a focus area, revised 02/19/2024, that indicated the resident had impaired cognitive function related to Alzheimer's dementia.</p> <p>An email, dated 04/17/2025, sent by Resident Representative (RR) #4 to the Director of Social Services (DSS) on behalf of Resident #10, indicated RR #4 wanted to know what the DSS had planned to do about Resident #10's missing property, and RR #4 requested that the plan for finding the property be submitted back to them in writing. The DSS replied to the email that RR #4's concerns had been placed on a grievance form and given to staff, and if the items were not found, the grievance would be elevated to the Administrator.</p> <p>An email, dated 05/22/2025 to the DSS from RR #4, revealed RR #4 again asked about Resident #10's missing items. The DSS replied to the email and indicated another concern form had been created, and the missing items had been discussed during a morning manager's meeting.</p> <p>A review of the facility's grievance log for 05/2025 revealed that on 05/22/2025 a Grievance Form was received from RR #4 on behalf of Resident #10. The form indicated Resident #10 was missing personal items, and RR #4 had requested to speak to the Director of Nursing (DON) and the Administrator. The grievance form indicated that the Environmental Services (EVS) Director participated in the investigation. The grievance form indicated that the EVS Director spoke with RR #4 and informed the RR that the missing articles had not been found, and the information would be given to the Administrator for replacement of the items. The form revealed the EVS Director signed the form, but no date was included for the resolution. The form indicated the Administrator met with RR #4, and RR #4 pointed out several maintenance issues. The form indicated that the Administrator told the maintenance supervisor. The form did not reflect a resolution or any corrective actions regarding the maintenance issues and also did not reflect whether the DON met with RR #4 as per their request. The form revealed a blank where resolution should have been documented, a blank in the space provided for the RR notification, and there was no date identified for resolution of RR #4's grievance.</p> <p>The Administrator was interviewed on 06/20/2025 at 1:45 PM and stated he saw RR #4 at least every other day. The Administrator stated that on 06/19/2025, RR #4 had reported that Resident #10 had clothing missing. The Administrator stated he requested a list of the missing items.</p> <p>(continued on next page)</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>RR #4 was interviewed on 06/23/2025 at 12:30 PM. RR #4 stated Resident #10's blue blanket had been missing since the fall of 2024, but RR #4 was unable to give a date for the missing hoodie and the resident's deodorant. RR #4 stated that on admission the facility tried to get them to label the resident's belongings, but they declined stating the resident's items were too nice and expensive to write the resident's name on the items. RR #4 stated the EVS Director reported to them on 06/23/2025 that the facility was going to reimburse for the blanket and the hoodie.</p> <p>An interview was held with the Social Services Designee (SSD) on 06/23/2025 at 3:50 PM. The SSD stated if a resident or family member had a grievance then the staff receiving the grievance gave the grievance to the social worker who wrote the grievance on a form. The SSD stated the grievance was given to the facility department involved for resolution. The SSD stated grievances should be resolved as soon as possible, adding that some grievances took longer than others. The SSD stated that when the grievance was resolved the grievance was returned to the DSS who reviewed the grievance, signed it as completed, and took the grievance to the Administrator. The SSD stated the Administrator then reviewed the grievance and signed off on the grievance. The SSD stated the social work department then called the complainant with the resolution, adding she was unsure if a written summary was given to the complainant.</p> <p>The DSS was interviewed on 06/24/2025 at 1:58 PM. The DSS stated when a grievance was received a grievance form was completed. The grievance form was then given to the appropriate department manager to complete. The DSS stated the best practice for completion of the grievance was within 48 to 72 hours but added that all grievances should be completed within a week. After a week, the DSS stated he spoke with the person assigned the grievance to find out the progress. The DSS stated once the grievance was completed and returned, he summarized what was done and not done on the grievance form. The DSS stated grievances involving reimbursement of clothing were routed to the Administrator or the corporate office. The DSS stated the facility encouraged family members to label clothing and to keep receipts for expensive items. The DSS reviewed RR #4's grievance regarding Resident #10, dated 05/22/2025, and the DSS stated copies of the grievance were given to the DON and the Administrator. The DSS stated he thought the Administrator had spoken with RR #4 but was unsure if the DON was in the building at the time. The DSS stated RR #4 wanted the replacement value for the clothing and not replacement clothing. The DSS stated the EVS Director was to speak with laundry about the resident's missing blanket and added he was unsure why the resident's laundry would end up in the facility's laundry since RR #4 did the laundry for Resident #10. The DSS stated if the missing items had not been found that information should have been written in the summary section of the grievance form. The DSS stated RR #4 knew the outcome of the investigation prior to 06/23/2024, as he and the RR spoke or exchanged emails daily. The DSS stated he had no documentation that indicated when RR #4 found out about the missing items. The DSS stated once resolution was achieved the department manager that received the grievance spoke directly to the complainant, and he was unaware a written summary was needed. The DSS stated that upon reviewing the grievance form submitted by RR #4 that it appeared the facility had done nothing.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The EVS Director was interviewed on 06/24/2025 at 2:40 PM. The EVS Director stated when a grievance was received for missing clothing he spoke to the resident, a family member, or a person from the facility that was familiar with the resident. The EVS Director stated he looked in the soiled utility room for the missing items, checked the resident's room, and added that his goal was to help the resident find their belongings. The EVS Director stated most of the time the article was found in the soiled utility room or in the laundry waiting to be washed or already washed and not delivered back yet. The EVS Director stated if the resident's belongings were not found he was expected to document that on the grievance form and stated he was expected to document on the grievance form that he had met with the resident and/or the RR about the items not being found. The EVS Director stated the same process was followed when family members washed laundry and had missing items. The EVS Director reviewed the grievance submitted by RR #4 that he had signed on 05/23/2025 and stated he had spoken to the RR about the missing hoodie. He stated he looked in the resident's room and the soiled utility room and the laundry. The EVS Director stated he reported to the Administrator that the resident's items were not found. He stated the Administrator agreed to refund the cost of the belongings. The EVS Director stated he had reported this to RR #4 a week prior.</p> <p>The DON was interviewed on 06/25/2025 at 8:43 AM. The DON stated resolution for a grievance should be obtained within three days to five days and feedback given to the person that voiced the grievance. The DON stated details of the investigation, and the date of resolution was documented on the grievance form. The DON stated if there was more than one department involved in the grievance each department got a copy of the grievance, and each department individually responded on their copy of the grievance. The DON stated she had not received a grievance addressed to her from RR #4 but stated she had spoken to RR #4 in the hall about Resident #10's missing clothing and identified that the timeframe of the conversation was the end of May 2025 to the beginning of June 2025. The DON stated RR #4 told her they had been promised the missing clothing would either be replaced or reimbursement given. The DON stated when RR #4 initially told her about the missing items she took care of the issue but had not completed a grievance form and had no documentation of when RR #4 had spoken to her. The DON stated she did not think RR #4 had received replacement or reimbursement for the clothing as of 06/25/2025. The DON reviewed the 05/22/2025 grievance and stated she had been unaware of the grievance and stated she realized not having documentation about her action on the missing clothing was a problem. She stated the missing clothing was brought up in the morning meeting and stated there had been other problems with missing clothing. The DON stated she expected grievances to be resolved timely, and the resident and/or RR notified of the resolution.</p> <p>The DSS was interviewed on 06/26/2025 at 9:59 AM, and email correspondence between RR #4 and the DSS were reviewed. After reviewing the email correspondence dated 04/17/2025 regarding Resident #10's missing items, the DSS stated he was unable to locate the 04/17/2025 grievance form and did not know what had happened to the grievance. The DSS stated that the resident and RR #4 had waited two months for a response. The DSS stated he had given a copy of the grievance to the EVS, the Administrator, and the DON on 05/22/2025, and the EVS was the only one that had responded. The DSS stated he followed up with RR #4 and as of 05/26/2025 the only person RR #4 had spoken with was the EVS Director. The DSS stated he had not followed up with the DON and Administrator for a response, but the expectation, as indicated on the grievance form, was that they document their response. The DSS stated he was responsible for making sure all parts of the grievance had been completed, and then the Administrator signed and dated the grievance. The DSS stated that on 05/26/2025 when he realized the grievance had not been completed he again approached the DON and Administrator. The DSS stated he was unsure if the Administrator or the DON had yet spoken with RR #4.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Administrator was interviewed on 06/26/2025 at 12:00 PM. The Administrator stated if any resident or RR emailed any department manager with concerns they could use the email as a submitted grievance, and he expected follow-up. The Administrator stated if the email was used as the grievance then he expected the complainant to be emailed or called with the resolution. The Administrator stated he had spoken with RR #4 about the clothing multiple times and had asked for a list of what was missing and had not received the list from the RR. The Administrator stated the only things RR #4 had mentioned as missing since before he began work as the Administrator was a hoodie and a blanket.</p> <p>Based on interview, record review, and facility document and policy review, the facility failed to investigate and resolve resident grievances related to missing clothing for 2 (Resident #1 and Resident #10) of 3 sampled residents reviewed for grievances.</p> <p>Findings included:</p> <p>A facility policy titled, Resident Grievance, dated 02/01/2025, indicated, The Grievance Official (and/or Grievance Committee, when required by state rule), shall complete a timely investigation of the resident's grievance. The policy also indicated, Grievances will be resolved in a reasonable timeframe, generally within 5 business days, consistent with the type of grievance.</p> <p>1. An admission Record indicated the facility admitted Resident #1 on April 2025. According to the admission Record, the resident had a medical history that included diagnoses of cerebral infarction, type 2 diabetes mellitus, and adjustment disorder with mixed anxiety and depressed mood.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/09/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition.</p> <p>Resident #1's Grievance Form, dated 06/02/2025, indicated staff were to ensure the resident: received a shower regularly; had their hair washed at least three times a week; received physical, occupational, and speech therapy; received their clothes from laundry; got out of bed; received a geriatric chair (a specialized reclining chair); and were changed timely. The Grievance Form had been addressed by therapy services, but there was no response from nursing or environmental services (EVS) indicated on the form.</p> <p>A copy of Resident #1's Grievance Form, dated 06/02/2025 with a resolution date of 06/19/2025, indicated all staff had been educated to provide showers, make the nurse aware if Resident #1 refused to get out of bed, and to promptly provide incontinent care.</p> <p>During an interview on 06/24/2025 at 2:15 PM, the Director of Social Services (DSS) stated whoever the grievance was assigned to should provide the follow-up to the complainant. The DSS stated the facility did not complete written summaries for follow-up on grievances. The DSS reviewed Resident #1's Grievance Form, dated 06/02/2025, and stated it was only resolved for therapy, and there was not a response from nursing or EVS. The DDS stated he would have to check for responses from nursing and EVS, and it looked like there needed to be some education on completing and responding to grievances.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/27/2025 at 8:40 AM, the DDS stated he did not find a response from EVS for Resident #1's grievance of 06/02/2025. The DDS stated he had just received nursing's response, and that was not appropriate.</p> <p>During an interview on 06/27/2025 at 9:00 AM, the Director of Nursing (DON) stated she expected missing clothing to be documented on a grievance form, housekeeping notified, and then they would start the process of looking for the missing clothing. The DON stated she recently found out that Resident #1 had an issue with missing clothing. The DON reviewed Resident #1's grievance of 06/02/2025 and stated it should have been resolved before 06/19/2025. The DON stated she expected grievances to be addressed in a timely manner.</p> <p>During an interview on 06/27/2025 at 12:21 PM, the EVS Director stated he did not see Resident #1's grievance dated 06/02/2025 until just the other day.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility document and policy review, the facility failed to thoroughly investigate an allegation of abuse for 1 (Resident #6) of 3 sampled residents reviewed for abuse.</p> <p>Findings included:</p> <p>An undated facility policy titled, Maryland Abuse, Neglect & Misappropriation, revealed, Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment and/or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property. The policy revealed the section titled, Procedure, included, V. Investigation of Incidents, 2. A Suspected Abuse d. Statements will be obtained from staff related to the incident, including victim, person reporting incident, accused perpetrator and witnesses.</p> <p>An admission Record revealed the facility admitted Resident #6 on March 2025. According to the admission Record, the resident had a medical history that included blindness in the right eye, normal vision in the left eye, and unspecified glaucoma.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/17/2025, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition.</p> <p>A facility investigation of an allegation of abuse reported to the facility on [DATE] by Resident #6's emergency contact revealed that the resident alleged that a person came into their room on 03/14/2025 and exposed themselves. During the investigation, the facility interviewed Resident #6 who denied the allegation. The facility investigation revealed police interviewed Resident #6 who denied that anyone exposed themselves but informed police that a person the resident did not recognize was at the door to their room and said from a distance that they liked what they saw referring to the resident's breasts and then walked away. The facility investigation revealed Resident #6 stated there had been no other incidents, and they had not seen that person before or since. The facility investigation revealed Resident #6 stated no one exposed themselves in the resident's presence, and the resident did not know why a family member told the facility that it happened. The facility investigation revealed law enforcement told the facility to follow the facility protocol, and they would not be conducting an investigation. The facility investigation revealed staff assigned to the area of the building where Resident #6's room was located were interviewed, and no witnesses were found. The facility investigation revealed a handwritten statement signed and dated 03/16/2025 revealed Registered Nurse (RN) #14 was told at the start of the 11:00 PM to 7:00 AM shift that a resident stated during the 3:00 PM to 11:00 PM shift a resident had stated that four men entered their room and mentioned the word breast. The facility investigation revealed that no other resident interviews were completed.</p> <p>On 06/25/2025 at 2:15 PM, the Assistant Director of Nursing (ADON) stated steps to investigate abuse included interviewing other residents to be certain that abuse was not happening with other residents.</p> <p>(continued on next page)</p>		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/27/2025 at 9:15 AM, the Director of Nursing (DON) stated abuse investigations should include resident interviews, other residents on the same unit, and witnesses and staff that were on duty. The DON stated that if the resident denied the allegation, the same process should be followed.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2025
NAME OF PROVIDER OR SUPPLIER Ellicott City Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 North Ridge Road Ellicott City, MD 21043	
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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to provide necessary care and services to maintain proper grooming and personal hygiene related to fingernail care and bathing for 1 (Resident #2) of 4 residents reviewed for activities of daily living (ADLs).</p> <p>Findings included:</p> <p>An undated facility policy titled, Resident Rights, indicated, Definitions: Dignity: a state worthy of honor or respect; includes but not limited to speaking respectfully to resident, providing privacy for care and treatment, providing safe and secure housing, sanitary food and hydration; respecting resident choice and attending to needs in a timely fashion.</p> <p>An admission Record revealed the facility admitted Resident #2 on December 2024. According to the admission Record, Resident #2 had a medical history that included unspecified osteomyelitis (bone infection), necrotizing fasciitis (flesh-eating disease), unspecified local infection of the skin and subcutaneous tissue, an unspecified pressure ulcer of the sacral region, and complete paraplegia.</p> <p>A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/27/2025, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident exhibited no behavioral symptoms and did not reject evaluation or care that was necessary to achieve their goals for health and well-being during the assessment's lookback period. The MDS revealed Resident #2 had functional limitations in range of motion with impairment of both lower extremities. The MDS indicated Resident #2 was dependent on staff for oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, and personal hygiene.</p> <p>Resident #2's Care Plan Report, included a focus area initiated 12/27/2024, that indicated the resident had ADL self-care performance deficit. Interventions directed staff to provide set up/clean up assistance with eating and place the call light within reach and remind the resident to call for assistance. The Care Plan Report included a focus area revised 06/13/2025 that indicated the resident had behavior problems including refusing medications and wound care. The focus area did not specify whether the resident refused personal hygiene or baths. Interventions directed staff to communicate with the resident/resident representative regarding behaviors and treatment (initiated 03/27/2025).</p> <p>A Behavior Monitoring & Intervention sheet for the timeframe from 05/20/2025 through 06/18/2025 revealed documentation that showed Resident #2 had no behaviors observed.</p> <p>Resident #2's March 2025 Documentation Survey Report revealed the section titled Shower/Bathe Self and Skin Observation indicated staff documented the resident received one bed bath and refused three baths, and that on four days, baths were not applicable.</p> <p>Resident #2's April 2025 Documentation Survey Report revealed the section titled Shower/Bathe Self and Skin Observation indicated staff documented the resident received six bed baths, refused one bath, was unavailable for one bath, and that on one day, a bath was not applicable.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Ellicott City Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 North Ridge Road Ellicott City, MD 21043	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #2's May 2025 Documentation Survey Report revealed the section titled Shower/Bathe Self and Skin Observation indicated staff documented the resident received one bed bath and two showers, refused one bath, and that on one date, a bath was not applicable.</p> <p>Resident #2's June 2025 Documentation Survey Report revealed the section titled Shower/Bathe Self and Skin Observation indicated staff documented the resident received five bed baths, refused no baths, and that on two days, baths were not applicable.</p> <p>The facility was unable to provide shower sheets to validate Resident #2 received showers during the timeframe from 03/2025 through 06/2025.</p> <p>An observation on 06/18/2025 at 11:25 AM revealed Resident #2's fingernails extended $\frac{14}{12}$ inch to $\frac{12}{12}$ inch beyond the tips of their fingers, and a black substance was noted under the resident's fingernails. During a concurrent interview, Resident #2 confirmed they needed assistance with nail care.</p> <p>An observation on 06/20/2025 at 10:00 AM revealed Resident #2's nails remained long, with the black substance still underneath the fingernails. During a concurrent interview, Resident #2 stated that staff had not offered to trim or clean their fingernails.</p> <p>An observation on 06/23/2025 at 9:30 AM revealed the condition of Resident #2's fingernails was unchanged as they remained long, with the black substance underneath the nails.</p> <p>Nursing Assistant (NA) #5 was interviewed on 06/23/2025 at 2:14 PM. NA #5 stated that the NAs were responsible for cleaning and trimming fingernails and that this was done as needed.</p> <p>NA #6 was interviewed on 06/23/2025 at 2:41 PM. NA #6 stated that Resident #2 did not refuse care but at times would want staff to wait until they were ready. NA #6 stated the NAs were responsible for clipping and cleaning fingernails. NA #6 stated she had been assigned to care for Resident #2 on 06/17/2025, 06/18/2025, 06/19/2025, 06/20/2025, and 06/23/2025. NA #6 stated Resident #2 was not able to clip their own nails, and she was unable to remember the last time she clipped the resident's nails. NA #6 reported Resident #2 had wounds and did not take showers and had not received a daily bed bath. NA #6 stated that if the resident wanted a bed bath, then the resident would request a bed bath. NA #6 stated she was unable to remember the last time she had washed the resident's legs or feet, and she had not washed the resident's legs and feet on the previous five days she had been assigned to care for Resident #2. NA #6 was unable to state why she had not given Resident #2 a bed bath. During a concurrent observation, NA #6 observed Resident #2's fingernails and agreed that the resident's nails needed to be cleaned and trimmed. NA #6 was unable to give a reason as to why she had not cleaned or trimmed the resident's nails.</p> <p>Licensed Practical Nurse (LPN) #7 was interviewed on 06/23/2025 at 2:57 PM. LPN #7 stated she was not assigned to care for Resident #2 but agreed the resident's fingernails needed to be cleaned and trimmed.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Assistant Director of Nursing (ADON) was interviewed on 06/23/2025 at 3:06 PM. During a concurrent observation, the ADON observed Resident #2's fingernails and stated the resident's nails needed to be trimmed and cleaned. Resident #2 told the ADON that they wanted their nails cleaned and trimmed. The ADON stated she expected residents' nails to be cleaned every time staff cared for them and trimmed as needed. The ADON stated that in the absence of a shower she expected residents to receive a daily bed bath.</p> <p>An interview was held with Resident #2 on 06/24/2025 at 11:30 AM. Resident #2 stated their nails had been trimmed after the observation on 06/23/2025.</p> <p>The ADON was interviewed on 06/25/2025 at 1:42 PM. The ADON stated she expected a bed bath to be offered as an option if a resident declined a shower. The ADON stated that a bed bath should be given daily. The ADON stated if the NA had not washed the resident's feet and legs, then the resident's bath had not been completed. The ADON stated she expected socks to be removed so that skin could be checked. The ADON agreed that when she observed Resident #2's fingernails, the nails were long and added she expected the NA to cut the resident's nails. The ADON stated not offering the resident a bed bath in the five days that NA #6 had been assigned to care for Resident #2 was unacceptable and not removing the resident's socks was unacceptable and unfortunate.</p> <p>The Director of Nursing (DON) was interviewed on 06/25/2025 at 2:46 PM. The DON stated bed baths should be offered daily and included washing the resident from head to toe. The DON stated during the bath that the resident's clothing, including socks, should be removed, and nail care was expected to be given as needed. The DON stated Resident #2 basically received no care from NA #6.</p> <p>The Clinical Manager Licensed Practical Nurse (CMLPN) #2 was interviewed on 06/26/2025 at 8:37 AM. CMLPN #2 was the clinical manager for the unit where Resident #2 lived. CMLPN #2 stated fingernails required cleaning and trimming as needed and added residents should not have to ask staff for a shower or a bed bath. He stated that it was expected that the NA would wash the entire body, removing the resident's socks so the skin could be inspected. CMLPN #2 stated he had been unaware Resident #2 had not received showers or bed baths, and it was the responsibility of the assigned nurse to make sure residents received baths. He stated that if the resident refused a bath, the NA was expected to report the refusal to the assigned nurse, and the nurse was expected to document the refusal. CMLPN #2 stated the condition of Resident #2's fingernails were brought to him on 06/23/2025 and he had personally trimmed the resident's fingernails. CMLPN #2 described Resident #2's fingernails as long and Horrible.</p> <p>The Administrator was interviewed on 06/26/2025 at 4:30 PM. The Administrator stated he expected a bath to be offered to Resident #2 daily by staff and expected nails to be cleaned and trimmed as needed. The Administrator stated Resident #2 refused care frequently, and he expected both the NA and the nurse to document refusals.</p>		