STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215160	A. Building B. Wing	11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ellicott City Healthcare Center	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, and interview, it was determined that the facility failed to ensure medications were administered based on professional standards of practice. This was evident for 1 of 1 medication administration observed during a complaint survey. The findings include: On 11/03/2025 at 8:01 AM, review of Complaint #2656373 revealed an allegation that medications were not administered as ordered.On 11/04/2025 at 9:00 AM, a random observation of Licensed Practical Nurse (Staff #13) administering medications to Resident #11 revealed several medications administered, two of which being Fluticasone-Salmeterol and Albuterol (both are inhalers which are medications given through the mouth by taking a deep breath to help breathing).Further observation revealed that Staff #13 administered one puff (one breath) of Fluticasone-Salmeterol and one puff of Albuterol. On 11/04/2025 at 9:40 AM, review of the medication administration record revealed that Fluticasone-Salmeterol and Umeclidinium Bromide (another type of inhaler) were signed off as administered during the 9:00 AM observation.Further review of Resident #11's medical record revealed that the Umeclidinium Bromide was due and should have been administered along with Fluticasone-Salmeterol, instead of the Albuterol inhaler that was observed administered to the resident.On 11/04/2025 at 10:24 AM, the surveyor reviewed the concern with the Director of Nursing regarding the observation made and she understood the concern.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint #2593162, observation, interview, and record review, it was determined that the facility failed to provide nail care to dependent residents. This was evident for 1 out of 1 resident (Resident #2) reviewed for Activities of Daily Living (ADL) care during the survey process.The findings include:The Brief Interview for Mental Status (BIMS) score is a number between 0 and 15 that indicates a person's cognitive health: 13-15 points: The person's cognition is intact; 8-12 points: The person has moderate cognitive impairment; 0-7 points: The person has severe cognitive impairment.Minimum Data Set (MDS) or MDS assessment, is a standardized, federally mandated clinical and functional assessment of residents in Medicare and Medicaid-certified nursing homes. The assessment helps nursing home staff understand a resident's strengths and needs to create an individualized care plan, monitor quality of care, and determine reimbursement. It is conducted upon admission, periodically (quarterly and annually), and upon discharge or when a resident's condition significantly changes.On 10/30/2025 at 8:41 AM, a review of complaint #2593162 alleged that Resident #2's care was not being met as evidenced by grossly long fingernails and black filth.On 10/30/2025 at 9:06 AM, surveyor's review of Resident #2's electronic health record revealed that he/she was admitted to the facility on [DATE] with diagnoses including but not limited to hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, aphasia following cerebral infarction, and type 2 diabetes mellitus with other diabetic complications.On 10/30/2025 at 9:17 AM, review of the resident's quarterly Brief Interview for Mental Status (BIMS) assessment, dated 10/10/2025, indicated a score of 15, signifying that Resident #2 was cognitively intact and review of GG (functional abilities) section on the MDS assessment also revealed that he/she was dependent for self care.On 10/30/2025 at 9:50 AM, an observation of Resident #2 revealed he/she had long fingernails with brown-colored material underneath the fingernails. On 10/30/2025 at 9:53 AM, during an interview, when Resident #2 was asked about his/her care at the facility, he/she stated that overall care could be better because the facility seems short-staffed. He/she further reported needing fingernails trimming but had not received assistance.On 10/30/2025 at 10:23 AM, during an interview, the Unit Manager (Staff #3), when asked what the expectation was regarding general skin and nail care, he stated that the expectation for skin and nail care was for staff to assess skin integrity and nail condition during showers. Staff #3 added that fingernails should be trimmed if needed or per residents' requests, and nurses would notify the podiatrist for toenail concerns.On 10/30/2025 at 10:26 AM, with the resident's permission, the surveyor and Staff #3 conducted a joint observation of Resident #2. Upon viewing the resident's long fingernails with brown-colored material underneath the fingernails, Staff #3 acknowledged the condition and stated that the fingernails nails would be trimmed and cleaned immediately. Staff #3 further stated that the Geriatric Nursing Assistant (GNA) who provided shower care on 10/28/2025 should have checked the fingernails at that time.On 10/30/2025 at 12:12 PM, when the Director of Nursing (DON) was informed about the concern, she stated that she had been informed by Staff #3 and that the facility would implement measures to prevent recurrence.On 10/30/2025 at 7:17 AM, review of Resident #2's progress note, dated 10/30/2025 at 2:25 PM, documented that the resident's fingernails were trimmed and filed as part of routine care. The note indicated that nails were cleaned prior to trimming, with no redness, cuts, or signs of infection observed. The resident tolerated the procedure well, and hands were washed and moisturized after care. The documentation further indicated that regular nail care would continue to promote hygiene and prevent skin injury.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on complaint #2593162, observations and interview with residents and facility staff, it was determined that the facility failed to ensure that food was delivered to residents at an appropriate and palatable temperature. This was evident for 1 out of 1 test tray temperature observations conducted during survey process. This deficient practice has the potential to affect all residents who receive meals prepared and delivered by the facility. The findings include:On 10/30/2025 at 8:41 AM, a review of complaint #2593162 alleged that Resident #2's food was always cold. On 10/30/2025 at 9:53 AM, during an interview with Resident #2, who resided on the Cedar Unit, the resident stated that meals always come very cold regardless of the meal and added that foods expected to be warm were cold by the time the tray arrived. On 11/03/2025 at 7:48 AM, the surveyor observed that it was only one Geriatric Nursing Assistant (GNA #6) passing the tray out on Cedar unit and there were several times the meal cart was left open and unattended to. On 11/03/2025 at 7:53 AM, during an interview with the facility's Chef/Certified Dietary Manager (Staff #7), when asked for the mealtime for breakfast, she stated that breakfast was typically served between 7:15 AM and 8:30 AM, depending on residents' preferences for early or late breakfast. When asked about expectations for honoring residents' preferences for warm meals, Staff #7 stated that the facility does not serve food that could burn residents and that if a resident complains of cold food, the meal is reheated. She further stated that any food past two hours would be discarded and replaced. On 11/03/2025 at 8:12 AM, Resident #2 was interviewed again. When asked about breakfast temperature, he/she stated that the food was cold as usual but ate it because of hunger, adding that he/she did not request reheating the food because he/she did not want to bother the staff. The surveyor informed him/her that meals could be reheated upon request, and the resident verbalized understanding. On 11/03/2025 at 8:30 AM, the surveyor requested a test tray corresponding to the last meal cart being delivered to Dogwood 1 Unit. Temperature readings were as follows: Orange juice: 40°F Milk: 39°F Coffee: 152°F Hot cereal: 140°F Eggs: 143°F(Cinnamon rolls and toast were not tested.) On 11/03/2025 at 8:33 AM, the last meal cart left the kitchen. On 11/03/2025 at 8:34 AM, the meal cart arrived on the unit, and the dietary aide announced its delivery. On 11/03/2025 at 8:39 AM, the surveyor observed an Licensed Practical Nurse (LPN #16) who was passing medications close the medication cart and begin serving meal trays. The meal cart was observed left open during meal distribution. The cart remained open intermittently when a Geriatric Nursing Assistant (GNA #17) joined to assist. On 11/03/2025 at 8:53 AM, the final resident tray was removed from the Dogwood 2 meal cart. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/03/2025 at 8:54 AM, during an interview with Staff #7, when asked for the standard temperature for cold foods, she stated that cold food should be maintained at 41°F or below and hot food at 135°F or above, with coffee and hot beverages not exceeding 150°F. When asked to conduct a dual temperature test of the same tray, both the surveyor and Staff #7 observed the following temperature readings: Orange juice: 53°F Milk: 52°F Coffee: 131°F Hot cereal: 122°F Eggs: 111°F(Cinnamon rolls and toast were not tested.) On 11/03/2025 at 8:59 AM, when Staff #7 was asked about the temperature decline, she stated that it was the responsibility of GNAs and nurses to deliver trays immediately upon arrival to the unit. She added that the facility previously used metal meal carts but transitioned to plastic carts after complaints about cold food persisted. When informed that the meal cart was left open during meal distribution, Staff #7 stated that carts should remain closed when not actively in use. On 11/03/2025 at 10:11 AM, in an interview with Licensed Practical Nurse (LPN #16), when asked what the expectation was regarding residents getting their meals and the expectation regarding maintain the meals temperature, she stated that meal trays should be distributed to residents immediately upon arrival to the unit and confirmed that Geriatric Nursing Assistants (GNAs) are primarily responsible for tray delivery. When informed that she was observed leaving the meal cart open, Staff #16 acknowledged the observation and stated she should have closed the cart while waiting for the GNA to retrieve trays to maintain the temperature of the meal. On 11/03/2025 at 10:16 AM, in an interview with Geriatric Nursing Assistant (GNA #17), when she was asked her expectation regarding maintaining the temperature of the meals in the meal cart, she stated that the expectation was to keep the meal cart closed after removing each tray. When informed she had left the cart open several times, GNA #17 acknowledged that this was inconsistent with expectations. On 11/03/2025 at 11:22 AM, when the concerns were discussed with the Director of Nursing (DON), she acknowledged the observation of open meal carts and stated that going forward, all staff would assist with prompt tray delivery to residents and receive education regarding maintaining cart closure when not actively serving meals. On 11/04/2025 at 8:24 AM, follow-up observation revealed that the facility had implemented a new practice of announcing meal cart arrivals to the units through an overhead speaker.