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 02/19/2026

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 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. Based on observation, record review and resident and staff interviews, it was determined that the facility failed to provide quality care that promotes resident respect and dignity. This was evident for one (Resident #67) out of five residents reviewed for dignity during the survey.The findings include:On 2/11/26 Resident #67 was observed sleeping in bed. Fingernails were long and unkept with dark build up underneath.On 2/13/26 at 1:26 PM this surveyor observed Resident #67's uncovered foot and noted exceptionally long toenails. The resident stated, I want them cut. They hurt me.On 2/13/26 at 1:29 PM this surveyor observed Licensed Practical Nurse (LPN #26) assess Resident #67 toenails. The resident pulled the foot away and stated, that hurts.In a follow-up interview, LPN #26 verified that the toenails are very long. He reported that the process to schedule a podiatry appointment was to verbally report it to social work.On 2/13/26 at 3:12 PM in an interview, Director of Social Service (DSS #21) explained the process to schedule a podiatry appointment for a resident. He stated that nurses should retrieve a Health Drive form from his office, complete it, have it signed by a Physician or Nurse Practitioner and also get a nurse signature and return it to his office. He, in turn, uploads the completed form to Health Drive and waits to receive an email confirming receipt of the request. If completed accurately and financial clearance is verified, then Health Drive schedules the appointment. He confirmed that he had not received any Health Drive forms today.On 2/17/26 at 9:15 AM this surveyor observed Resident #67's toenails remained very long. On 2/17/26 at 9:17 AM in an interview with DSS #21 confirmed that a completed Health Drive form was received and uploaded; Resident #67's podiatry appointment was scheduled for 2/20/26.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, pertinent document review, and interview it was determined that the facility failed to maintain a safe, comfortable and homelike environment. This was evident for 7 (Resident #1, #8, #40, #66, #90, #127, #140) of 15 residents reviewed during the environmental task, in addition to multiple random observations of elevated hot water in resident rooms on both floors of the facility which put all residents at risk of being affected by this deficient practice.The findings include: 1) On 2/10/26 at 9:35 AM, the surveyor interviewed Resident #127 and observed that the resident's bathroom had a loose plastic threshold on the floor of the shower and a shower chair with a jagged piece of plastic protruding in the area that a person would sit. The surveyor also noted the sink is extremely discolored with a brown circular stain and is cracked. The drywall had multiple gouges. During this observation, GNA #27 confirmed the surveyor's observations. On 2/10/26 at 10:00 AM, the surveyor interviewed roommates (Residents #66 and #90), who pointed out a large, thick area of thick spackle on the wall that was rough in texture (had not been sanded) and without paint. They also identified several additional areas around the bedroom and bathroom with unsanded or unpainted spackling, gouges in the drywall, sink and toilet stains, and gouges in the toilet bowl. The surveyor noted a gap in the wall near the pipes under the sink. On 2/10/26 at 1:02 PM, during an interview with Resident #1, the surveyor observed their bathroom, noting extensive drywall damage with gouges, rough spackling, and holes around the piping under the sink. On 2/10/26 at 10:33 AM, Resident #8 pointed out that their bedroom had wear and tear, with paint and drywall pulling away, and a handle on their dresser drawer was coming off (it was hanging by one screw). Multiple areas of chipped paint were observed, and the bathroom sink had cracks and discoloration. On 2/10/26 around 11:00 AM, the surveyor noted during the initial screening that the sink in Resident #40's room was slow to drain, cracked, and stained. On 2/13/26 at 4:08 PM, the surveyor interviewed the Maintenance Director (MD #8) regarding the process for keeping the building in good repair and whether environmental rounds are conducted. He stated that they are trying to play catch-up for needed repairs and are aware of many walls that need paint and drywall repair, but there is no planned date to complete these repairs. Regarding gaps around several bathroom pipes, he reported a plan to install plastic pieces that snap around the pipes, but no timeline was provided. He also noted that several sinks were cracked and stained and stated they would only be replaced if they started to leak. On 2/13/26 at 4:25 PM, the surveyor interviewed the Nursing Home Administrator (NHA), who expressed awareness of areas needing paint and acknowledged concerns about gaps around piping. He stated that corporate painters come periodically but was unsure when they would return. On 2/17/26 at 12:00 PM, the surveyor toured rooms with the NHA, who confirmed concerns in each area: -Resident #8: Wall damage and loose drawer handle (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Residents #66 and #90: Damage to multiple walls, rough spackle without sanding, missing paint, sink and toilet cracks/discoloration, pipes exposed under sink -Resident #127: Cracked/stained sink, cracked shower chair (immediately removed by NHA), loose threshold, exposed pipes -Resident #40: Cracked/stained sink When asked if he wanted to look at Resident #1's room, the NHA stated, No, I believe this is a concern. 2) On 2/10/26 at 9:25 AM, during the initial screening process, Resident #140 stated that the facility is often out of soap, towels, and washcloths, impacting their ability to get a bath or shower. On 2/17/26 at 12:38 PM, the surveyor asked the NHA if he was aware of the facility being short of linens such as washcloths or towels. He stated that he was not aware and reported that he had recently purchased washcloths. On 2/17/26 at 12:40 PM, the surveyor interviewed GNA #27, who reported frequent shortages of washcloths and towels and reported delays in providing ADL (Activities of Daily Living) care, stating, I try to plan ahead and improvise since this has been an issue. On 2/17/26 at 12:44 PM, the surveyor interviewed GNA #37, who reported very often a shortage of towels and washcloths, impacting her ability to give bed baths and showers. On 2/17/26 at 12:46 PM, the surveyor informed the NHA that residents had complained about linen shortages and that GNA staff confirmed these shortages were impacting timely care. The NHA acknowledged that the issue might be related to laundry rather than supply but stated that a systemic change was needed. On 2/19/26 at 11:39 AM, the surveyor reviewed environmental concerns with the NHA and at 12:15 PM reviewed the concerns with the Director of Nursing (DON). Both confirmed that the findings were issues and reported they were working on changes. On 2/19/26 at 1:48 PM, the NHA stated he was unable to find a policy about maintaining a home-like environment or conducting environmental rounds but would continue looking. At survey exit, no policy was provided to the surveyor. 3)On 2/10/2026 at 10:55 AM, the water temperature was taken in the bathroom of resident room [ROOM NUMBER]. The temperature was 125 degrees Fahrenheit. On 2/10/26 at 10:56 AM, the water temperature was taken in the bathroom of resident room [ROOM NUMBER]. The temperature was 126.3 degrees Fahrenheit. On 2/10/26 at 10:59 AM, the water temperature was taken in the bathroom of resident room [ROOM NUMBER]. The temperature was 123.7 degrees Fahrenheit. On 2/10/26 at 11:06 AM, maintenance staff (Staff #44) was interviewed. Staff #44 reported checking water temperatures in one room on every unit early each morning. Staff #44 stated that water (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	temperatures should be maintained between 110 and 120 degrees Fahrenheit. Staff #44 reported taking water temperatures on the morning of 2/10/26 and provided a copy of the readings to the survey team. Staff #44 confirmed the temperature readings were in Fahrenheit. Staff #44 stated that the temperatures taken that morning had not been reported to the supervisor or the facility administrator. Staff #44 could not recall the specific rooms tested. On 2/10/26 at 11:08 AM, review of the water temperature document taken the morning of 2/10/26 revealed the following readings, which Staff #44 confirmed were degrees Fahrenheit: Apple Blossom Unit: 124.5Cherry Unit: 120.9Cedar Unit: 126.7Dogwood Unit: 125.1 On 2/10/26 at 1:13 PM, during a brief interview, the Administrator and the Maintenance Director reported they were unaware of the temperatures taken by Staff #44. On 2/10/26 at 1:14 PM, the surveyor, Administrator, and Maintenance Director observed the water temperature in room [ROOM NUMBER]. The temperature was 122 degrees Fahrenheit. The Maintenance Director confirmed that water temperature checks were conducted first thing each morning. On 02/10/26 at 1:33 PM, the Administrator reported that the water temperature at the boiler had been lowered and that a plumbing company had been contacted to resolve the issue. On 2/11/26 at 12:00 PM, a request was made to the Maintenance Director for a copy of the morning water temperatures. The Maintenance Director reported that morning temperatures had not been taken. On 2/11/26 at 1:00 PM, the surveyor obtained random bathroom sink water temperatures in resident rooms using a calibrated digital thermometer. The following temperatures were recorded: room [ROOM NUMBER]: 128.9 degrees F room [ROOM NUMBER]A: 124.3 degrees F room [ROOM NUMBER]A: 127.4 degrees F At 1:09 PM, Resident #140 stated, Be careful if you are checking the water temperatures, implying the water became excessively hot. On 2/11/26 at 1:40 PM, the Maintenance Director provided water temperature log dated 2/11/26 at 1:40 PM. Review of the log revealed the following: room [ROOM NUMBER]: 125 degrees [NAME] 142: 137 degrees [NAME] 222: 127 degrees F On 2/11/26 at 2:20 PM, the surveyor returned to the unit to recheck water temperatures after the facility announced the hot water system was being shut down for repair. The following temperatures were recorded: room [ROOM NUMBER]: 121.8 degrees [NAME] 200: 120.9 degrees F On 2/11/26 at 4:57 PM, the Administrator confirmed that the hot water had been shut off; however, some residual hot water remained in the pipes. The Administrator reported that staff were aware of (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the issue. He reported that the hot water would be shut of until the repairs have been completed. On 2/17/2026 from 10:37 AM to 11:38 PM, the Administrator reported that all plumbing repairs had been completed. Surveyors and the Administrator took water temperatures in rooms on every unit in the facility. All temperatures were within normal limits of 110-120 degrees Fahrenheit.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review, observations, and interviews, it was determined that the facility failed to protect residents from verbal abuse. This was evident for two (Residents #90 and #111) out of six residents reviewed for abuse allegations.The findings include:1) Resident #90 has a medical history of heart failure, depression, and post-traumatic stress disorder.On 1/28/26 at 5:26 PM, the facility submitted a facility-reported incident to the Office of Health Care Quality (OHCQ) stating that an Activities Assistant (AA #29) had a verbal altercation with Resident #90 (Incident #2729623).On 2/12/26 at 4:22 PM, the surveyor reviewed the facility's investigation regarding the allegation of verbal abuse. The report indicated that Resident #90 informed Unit Manager (UM #10) that AA #29 had delivered cigarettes to another resident. When Resident #90 asked to borrow one, the other resident stated that AA #29 had told them Resident #90 takes advantage of other residents and declined to share. Upset by this accusation, Resident #90 approached AA #29 to ask why this was said. Resident #90 reported that AA #29 responded, I bought the f&$king cigarettes, and I don't care who the f&$k gets mad, I paid for them, followed by additional profanity. Resident #90 stated the verbal attack upset her, and she chose to report the incident rather than respond.On 2/12/26 at 4:00 PM, the surveyor interviewed Resident #90, who stated she clearly remembered the event. She reported seeing AA #29 bringing cigarettes into another resident's room and asking to borrow one. She stated the other resident told her that AA #29 had accused her of taking advantage of others. When she questioned AA #29 about this, AA #29 became irate and screamed at her using a lot of bad language. Resident #90 further stated she had not reported prior concerns but that there had been three previous incidents involving the staff member.On 2/12/26 at 4:36 PM, the surveyor interviewed the Director of Nursing (DON), who conducted the investigation. The DON stated AA #29 was immediately suspended pending investigation. She reported the allegation was substantiated through staff and resident interviews, which revealed additional concerns regarding the staff member's treatment of non-favorite residents. The DON stated AA #29 had also been heard telling another resident, I wouldn't give you sh$t if you asked for it.2) Resident #111 has a medical history significant for a stroke with left-sided hemiplegia (severe weakness or total loss of function), heart disease, depression, and dysphagia (difficulty swallowing).On 2/10/26 at 12:26 PM, an OHCQ nurse surveyor and survey coordinator were standing outside the second-floor nurse station conducting general observations when they overheard a staff member loudly state, You need to get your s&it together and eat, you are a grown a$$ [sex of resident removed]. The surveyors observed a resident seated in a geri-chair with a lunch tray in front of them and two staff members walking away toward the food cart. The surveyors were unable to determine which staff member made the statement. The tray ticket identified the resident as Resident #111. The surveyor noted the resident had a blank expression. When asked if assistance was needed, the resident responded, no.On 2/10/26 at 1:46 PM, the surveyors reported the incident to the Nursing Home Administrator (NHA), who stated an investigation would be initiated and the DON notified. Shortly thereafter, the DON informed the surveyors that both staff members observed near the resident would be suspended pending investigation and confirmed that they had completed an initial self-report (Incident #2740371) to OHCQ.On 2/10/26 at 4:15 PM, the surveyors interviewed Resident #111 regarding the incident. The resident stated, the nurse (identified as Nursing Assistant (NA #14)) gets like that with her sometimes. When asked if she felt safe in the facility, she responded, sometimes.On 2/19/26 at 11:39 AM, the surveyor interviewed the Nursing Home Administrator (NHA). The NHA stated the facility was unable to conclusively identify which staff member made the abusive statement because Resident #111 later recanted the allegation. He acknowledged that residents have expressed fear (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of retaliation from staff and stated this fear may have contributed to Resident #111 withdrawing her statement. Despite the recant, he confirmed he believed the incident did occur based on the firsthand observations and written statements of the OHCQ surveyor and survey coordinator. He reported both suspected staff members denied involvement and, due to the lack of resident confirmation, he could not take definitive disciplinary action but stated the facility would continue to monitor the suspected staff. The NHA acknowledged the language used constituted verbal abuse and stated the allegation was amended from unsubstantiated to substantiated, as the abusive event itself was verified even though the specific perpetrator could not be identified.On 2/19/26 at 12:20 PM, the NHA notified the surveyor that the final report had been updated and amended accordingly.

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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. Based on interviews, observations, and record review, it was determined that the facility failed to provide ADL (activity of daily living) care to residents. This was evident for two (Resident #6 and Resident #10) out of three residents reviewed for ADL care.The findings include:Activities of Daily Living (ADL) care refers to support provided to individuals who struggle with essential, routine self-care tasks necessary for basic health, safety, and hygiene.1) Resident #6 has a medical history of diabetes, end-stage kidney disease requiring dialysis, and abnormalities of gait and mobility requiring assistance with ADL care.On 2/10/26 at 4:45 PM, the surveyor interviewed Resident #6 and observed that s/he looked disheveled with greasy hair and body odor. The resident mentioned that s/he often waits up to five hours without incontinence care and stated that they get a little wet towel bath but no real cleaning. The surveyor noted that the bedding was disheveled, the resident was only wearing an incontinence brief, and a dressing on the chest was falling off.On 2/17/26 at 2:27 PM, the surveyor performed a record review of Resident #6's shower and bath records and had difficulty determining if the resident was given baths as ordered. The care plan revealed that the resident is unable to have a shower due to a dialysis port implanted in the chest.On 2/17/26 at 4:01 PM, the surveyor conducted an interview with the Director of Nursing (DON) and the Regional Clinical Director (RCD) and asked for clarification about the documentation for Resident #6's bath schedule. They presented a document titled GG Shower/Bath Self and Skin Observation. The paper asks the question, Type: Bath/Shower, with a place for a response. Several dates stated Response not Required. The RCD explained that response not required means that no bed bath was given that day. The resident did not receive a bath on 1/6, 1/13, 1/20, 1/23, and 1/27/26. Additionally, they provided evidence of one bed bath for the month of February on 2/13/26 (no other dates for February). The surveyor expressed concern that the resident had not been getting baths as ordered, and both agreed this was a valid concern.On 2/18/26 at 10:59 AM, the DON approached the surveyor and stated that Resident #6 had been given a bath. The surveyor went to the resident's room and verified that they had received a bath. The resident was very happy and thankful for the bath and stated they felt much better.2) On 2/11/26 at 10:04 AM, the surveyor conducted an interview with Resident #10, who is dependent on staff for ADL care. S/he stated that they only receive showers about every two months and would like them more often.On 2/17/26 at 2:36 PM, the surveyor conducted a record review and was unable to find evidence that the staff had provided baths or showers and requested evidence from the DON.On 2/17/26 at 4:01 PM, the surveyor conducted an interview with the DON and RCD and asked for evidence that Resident #10 had been provided showers. The RCD stated that, based on the chart, it appears that an error had been made and showers and baths had not been tracked.On 2/18/26 at 10:40 AM, the DON confirmed that they were unable to provide evidence that the resident had received a bath or shower because of the system error when showers and baths were set up. She stated she was trying to find shower sheets and would provide them if they existed. About an hour later, she provided the surveyor with skin assessment sheets that stated bed bath for 1/7, 1/27, 1/30, 2/10, and 2/13/26. There is no record of any other bed baths or of the resident receiving showers.