

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/27/2026
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)		
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility investigative record review, medical record review, and staff interviews, it was determined that the facility failed to ensure a cognitively impaired resident remained free from sexual abuse. This was evident for 1 (Resident #22) of 7 residents reviewed for abuse during the complaint survey. This deficient practice resulted in Immediate Jeopardy. However, the facility developed, implemented, and completed corrective actions prior to the start of this survey. The facility's plan and action were verified during this survey, therefore this deficiency was found to be past noncompliance with a compliance date of 4/10/2026. The findings include: The Minimum Data Set (MDS) is a comprehensive assessment completed by facility staff that evaluates a resident's cognition, behaviors, functional abilities, and care needs. The Brief Interview for Mental Status (BIMS) is an assessment used to determine a resident's cognitive status. A score of 13-15 indicates cognitively intact, 8-12 indicates moderate cognitive impairment, and 0-7 indicates severe cognitive impairment. A review of Facility Reported Incident (FRI) #2974322 on 7/7/2026 at 10:06 AM revealed an allegation that Resident #23 engaged in sexual activity with Resident #22 on 4/2/2026. A review of related Complaint #2972968 on 7/7/2026 at 10:38 AM, revealed an allegation of sexual assault involving Resident #22. A review of the facility's investigative documentation on 7/7/2026 at 11:15 AM revealed that on 4/2/2026, multiple facility staff members observed Resident #23 engaged in sexual activity with Resident #22. The facility's investigation revealed that staff who observed the sexual activity exited the room, closed the privacy curtain, or closed the room door without immediately intervening or separating the residents. Continued review revealed the incident was subsequently reported to facility administration, law enforcement was notified, Resident #23 was placed on one-to-one supervision until law enforcement arrived, and Resident #23 was removed from the facility on 4/2/2026. The facility's investigation verified the allegation through witness statements obtained during the investigation. A review of Resident #22's clinical record revealed diagnoses including vascular dementia, cognitive communication deficit, major depressive disorder, post-traumatic stress disorder, and hemiplegia (paralysis on one side of the body) following cerebral infarction (stroke). Review of Resident #22's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 11, indicating moderate cognitive impairment. Continued review of Resident #22's clinical record revealed two Physician Certifications Related to Medical Condition, Decision Making and Treatment Limitation forms dated 1/30/2024 and 2/20/2024. The forms revealed Resident #22 lacked decision-making capacity, including the ability to make medical treatment decisions. Continued review of Resident #22's nursing documentation dated 4/2/2026 revealed that the resident's responsible party (RP) requested the resident be transferred to the emergency department (ED) for further evaluation following notification of the incident. The attending physician was notified, and Resident #22 was (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	transferred to the ED after law enforcement responded. Further review of Resident #22's psychiatric consultation dated 4/3/2026 revealed the resident was guarded, irritable, reluctant to engage, and declined to discuss the reported incident. The consultation documented the resident responded, Maybe I do, maybe I do not, when questioned about recall of the event. Review of Resident #22's physician progress note dated 4/14/2026 revealed Resident #22 returned from the emergency department following forensic evaluation. The physician documented no acute injuries were identified and further documented Resident #22 lacked capacity due to dementia, had impaired judgment, impaired short- and long-term memory, and relied upon the RP to make healthcare and financial decisions. On 7/7/2026 at 11:45 AM, Resident #23's clinical record was reviewed to reveal Resident #23's admission MDS assessment which documented a BIMS score of 15, indicating cognitively intact. Review of Physical Therapy Aide (PTA) #20's witness statement dated 4/2/2026 revealed that at approximately 12:00 PM, PTA #20 entered Resident #22's room for scheduled therapy and observed Residents #22 and #23 engaged in sexual activity while both residents were in bed. The witness statement further documented that PTA #20 exited the room without intervening. On 7/7/2026 at 12:16 PM, an interview with PTA #20 confirmed the written witness statement. PTA #20 stated he/she exited the room, asked a GNA in the opposite room whether they knew what was occurring, continued providing therapy according to her schedule, and did not report the incident to the Director of Rehabilitation until approximately two hours later. On 07/08/2026 9:35 AM in an interview with GNA #21, it was revealed that on 4/2/2026 she was picking up breakfast meal trays when she entered Resident #22's room and found the door closed and the curtain drawn which was unusual for Resident #22. GNA #21 stated that when she pulled the curtain back, she saw Resident #23 sitting on top of Resident #22's face. GNA #21 stated she could not see all of Resident #22's face and Resident #23 was smiling. The GNA further stated that she closed the curtain, left the room and closed the door. GNA #21 stated she did not intervene or separate the residents before leaving the room. GNA #21 also stated that she reported the incident to the nurse on duty, LPN #22. On 07/08/2026 at 9:58 AM, in an interview, LPN #22 stated that she did not see what happened between Residents #22 and #23 and that she only became aware of the incident when the former DON asked for her statement. LPN #22 further stated that no GNA reported the incident to her. Review of Maintenance Assistant #3's witness statement dated 4/2/2026 revealed Maintenance Assistant #3 transported Resident #22 to their room to be cleaned up. When Maintenance Assistant #3 returned to check on Resident #22, he observed Resident #23 sitting on Resident #22's face. The witness statement further revealed that Maintenance Assistant #3 informed GNA #23 of what he observed. On 07/08/2026 at 10:05 AM, an interview with Maintenance Assistant #3 confirmed the written witness statement. Maintenance Assistance #3 stated he wheeled Resident #22 to his/her room so that staff could help him/her get cleaned up. Maintenance Assistant #3 stated that when he went back about thirty minutes later to check to see if Resident #22 was still in his/her room, he saw Resident #23 sitting on Resident #22's face. Maintenance Assistant #3 stated he told GNA #23, who he thought was assigned to Resident #22, and then he went and shut the door. Maintenance Assistant #3 did not intervene or separate the residents. On 07/08/2026 at 10:50 AM, in an interview, GNA #23 stated that Resident #22 was not in her assignment, but that Maintenance Assistant #3 asked her to go look in Resident #22's room. GNA #23 stated that when she got to the room she observed Resident #23 sitting on the edge of Resident #22's bed with his/her clothes on. GNA #23 further stated that this happened right before lunch and when she found the nurse, she was already aware of the incident. On 7/9/2026 at 11:59AM, in an interview, Social Worker #25, stated an unknown GNA reported to her that they saw Resident #23 sitting on top of Resident #22. Social Worker #25 further stated that when she contacted the former (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	DON via phone about the incident, the former DON stated that this was the second time this had happened today. On 7/7/2026 at 12:39 PM, an interview with the Director of Nursing (DON) revealed that at the time of the alleged incident, 4/2/2026, she served as the facility's Regional Nurse and was not notified of the incident until 4/5/2026 by the former DON. The DON stated that Resident #23 was removed from the facility on 4/2/2026 and Resident #22 received medical evaluation and psychological services following the incident. The DON further stated staff should have intervened immediately once the interaction was observed and should have separated the residents. On 7/09/2026 at 2:00 PM, the Executive Director and DON were notified that the facility failed to protect a cognitively impaired resident (Resident #22) from sexual abuse after multiple staff members observed Resident #23 engaging in sexual activity with Resident #22 and failed to immediately intervene to stop the abuse. Facility staff acknowledged observing the sexual activity but exited the room, closed the curtain, or shut the door without separating the residents. The facility's failure to immediately intervene allowed the sexual abuse of Resident #22 to continue after multiple staff members observed the incident and demonstrated facility staff failed to protect residents from abuse. The facility's corrective actions included: Placing Resident #23 on one-to-one supervision until law enforcement arrived on 4/2/2026. Removing Resident #23 from the facility on 4/2/2026. Transferring Resident #22 to the emergency department for evaluation and completing a forensic examination. Completing a psychological evaluation of Resident #22 following return to the facility. Conducting an Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting on 4/7/2026 to address staff response to resident-to-resident sexual abuse and reporting expectations. Completing facility-wide education regarding abuse prevention, reporting requirements, and immediate staff intervention. Providing resident council education regarding reporting concerns and resident safety. Implementing admission audits and ongoing monitoring to identify and address residents at increased risk for abuse. A review of facility documentation and staff interviews revealed the facility completed corrective actions on 4/10/2026. This deficient practice was cited as past noncompliance with Federal and State requirements with a compliance date of 4/10/2026.		

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on observation, medical record review and interview, it was determined the facility staff failed to document in the residents' medical record if notification of a room change was made to residents and the residents' representative. This was evident for 4 (Resident #28, #29, #30 and #31) of 9 residents reviewed for room transfers during a complaint survey. The findings include: Review of a facility reported incident 3063858 was conducted on 7/7/26 regarding a plumbing backflow on the Magnolia Unit. Observation of Rooms 111 through 125 on 7/7/26 at 7:55 AM revealed the Rooms were behind 2 closed doors, the middle of the hallway floor tile had been removed and cement was exposed. At the time 2 contractors were in the affected area providing repairs. During interview of Contractor #5 at that time, he stated the plumbing work had been completed and they were there to work on the floor replacement and clean up. Further observation of the affected area on 7/7/26 revealed no residents were residing in Rooms 111 through 125, there were no odors, the sinks and toilets were functional and no water backup was noted from the shower drains. Review of facility documentation provided by the Director of Nursing on 7/7/26 revealed on 6/28/26 21 residents were relocated in the facility due to the backup of drainage water in the hallway and shower drains for Rooms 111-125, part of the Magnolia Unit. Nine of 21 residents' medical records were reviewed on 7/14/26 for documentation of notification to the resident and the representative after the residents were relocated on 6/28/26. Residents #28, #29, #30 and #31 did not have a Notification of Room Change evaluation completed. During interview with the Director of Nursing (DON) on 7/14/26 at 10:14 AM, the DON stated the Social Worker was supposed to ensure that the Notification of Room Change was completed for all 21 residents affected. The DON added the Social Worker is currently on leave. Interview with the DON on 7/14/26 at 10:30 AM confirmed the facility staff failed to document if Residents #28, #29, #30, #31 and the residents' representatives were notified of the room change that occurred on 6/28/26.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on review of medical records, facility documentation review and interviews, it was determined the facility failed to provide documentation that allegations of abuse, neglect and injury of unknown origin were thoroughly investigated. This was evident for 6 (Resident #1, #3, #4, #17, #8, #6) of 16 residents reviewed for facility reported incidents during a complaint survey. The findings include: 1) A review of facility reported incident 2745896 was conducted on 7/7/26 regarding Resident #1's allegation that LPN (licensed practical nurse) #39 purposely delayed the administration of his/her medications to cause him/her anguish. Review of the facility investigation documentation provided by the Director of Nursing on 7/7/26 revealed no statement from Resident #1, LPN #39 or any other staff. Although 10 residents were interviewed, they were only asked if they had been abused. There is no indication the 10 residents were interviewed regarding the delay in medication administration by LPN #39. Interview with the Director of Nursing on 7/9/26 at 1:05 PM confirmed the investigation for facility reported incident 2745896 was incomplete. 2) A review of facility reported incident 2783643 was conducted on 7/10/26 regarding Resident #3 allegation he/she heard GNA (geriatric nursing assistant) #27 state: I am not getting him/her up. It's my day off and I only came in today for the bonus they offered. Review of the facility's investigation documentation on 7/10/26 provided by the Director of Nursing revealed there were no staff or resident interviews to see if anyone witnessed GNA #27's alleged statement. Interview with the Director of Nursing on 7/10/26 at 8:45 AM confirmed the investigation for facility reported incident 2783643 was incomplete. 3) A review of facility reported incident 2784272 was conducted on 7/9/26 regarding Resident #4's allegation that when he/she called the nurse's station for assistance the staff were laughing about his/her request. Review of the facility's investigation documentation on 7/9/26 provided by the Director of Nursing revealed there were no staff statements or interview of Resident #4 regarding the allegation. Further review of the investigation documentation revealed there was no evidence that facility submitted the required Follow-up Investigation Report Form to the Office of Health Care Quality. Interview with the Director of Nursing on 7/9/26 at 2:00 PM confirmed the investigation for facility reported incident 2784272 was incomplete and the facility had no evidence they had submitted the required Follow-up Investigation Report Form to the Office of Health Care Quality. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) On 7/9/26 at 8:55 AM a review of facility reported incident 3025308 and Resident #17's medical record was conducted. Review of the investigation revealed Resident #17 told the speech therapist on 5/27/26 at approximately 10:50 AM that he/she had his/her gown ripped off and was raped and beaten. The investigation revealed a written statement from Geriatric Nursing Assistant (GNA) #40 that documented on 5/27/26 at around 9:30 AM Resident #17 told her that another resident tried to rape him/her last night. Further review of the facility's investigation revealed that seven staff members who worked on the first floor during the 3:00 PM to 11:00 PM shift and the 11:00 PM to 7:00 AM shift were not interviewed or did not have documented written statements. Review of the assignment sheets provided to the surveyor by the Director of Nursing (DON) showed a staff member's name on the sheet, but that staff member was not on the schedule. GNA #41 was assigned to the resident on 5/26/26 for 3:00 PM to 11:00 PM however there was no written statement from GNA #41. On 7/9/26 at 1:07 PM the DON was interviewed and stated that the previous DON and Nursing Home Administrator (NHA) were not following the process of sending the 5-day report and investigation to the regional team, preventing the regional team from following up to ensure the investigation was complete. The DON confirmed the surveyor's findings. 5) On 7/10/26 at 7:30 AM a review of facility reported incident 3001828 and Resident #8's medical record was conducted. Review of the investigation revealed Resident #8 alleged that GNA #42 said to the residents at the elevator, I am tired of these [expletives]. A review of the facility's investigation failed to produce staff interviews regarding the incident and GNA #42. There was no documentation of how GNA #42 worked with the residents. There was only 1 resident statement. On 7/14/26 at 1:01 PM the DON was interviewed about the completeness of the investigation. The DON confirmed that there were no other staff interviews about GNA #42's credibility about how she treated other residents and if she ever had any outbursts of profanity towards the residents. The DON confirmed that the investigation only included 1 resident statement and not the other 2 residents who were supposedly at the elevator when the incident occurred. The DON stated it would have been necessary to get the witness and the other resident statements. 6) On 7/14/26 at 9:24 AM a review of facility reported incident 2968971 and Resident #6's medical record was conducted. Resident #6 had alleged abuse. The NHA was unable to provide the surveyor with an investigation. The only documentation was on the 5-day report that OHCQ received, however it was not a detailed investigation. The facility was unable to provide the surveyor with resident assessments, interviews, or any staff member interviews regarding the incident. On 7/14/26 at 1:35 PM the NHA confirmed to the surveyor that he never found the initial report, the 5-day report, or the investigation. The NHA stated, I gave you everything I have.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on medical record review, observation and interviews, the facility staff failed to ensure a resident's call bell was in reach. This was evident for 1 (Resident #12) of 5 residents observed for call bells during a complaint survey. The findings:Review of Resident #12's medical record on 7/7/26 revealed the Resident was admitted to the facility in 2017 and has a diagnosis to include legal blindness.During interview of Resident #12 on 7/7/26 at 9:46 AM, the Resident stated he/she needed assistance repositioning in bed, the Resident was asked at that time if he/she knew where his/her call bell was to alert staff. The Resident stated he/she was legally blind and did not know where his/her call bell was.Observation of the Resident's call bell on 7/7/26 at 9:46 AM revealed it was sitting on top of the Resident's oxygen concentrator approximately 2 feet from the Resident's bed and not in the Resident's reach.The Surveyor asked Unit Manager #9 to come to the Resident's room. Unit Manager #9 arrived at the Resident's room on 7/7/26 at 9:49 AM. At that time Unit Manager #9 confirmed the Resident's call bell wasn't in reach of the Resident.Unit Manager #9 advised the Surveyor on 7/7/26 at 10:10 AM he had put a clip on the Resident's call bell to ensure it was in reach for the Resident.The Surveyor advised the Director of Nursing of the Surveyor's findings on 7/9/26 at 10:57 AM.		

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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. Based on review of facility reported incident, documentation review, and interviews, it was determined the facility failed to report an alleged abuse immediately to the Nursing Home Administrator and within 2 hours to the regulatory agency, the Office of Health Care Quality (OHCQ). This was evident for 1 (Resident #17) of 16 residents reviewed for facility reported incidents during a complaint survey. The findings include: On 7/9/26 at 8:55 AM a review of facility reported incident 3025308 and Resident #17's medical record was conducted. Review of the investigation revealed Resident #17 told the speech therapist on 5/27/26 at approximately 10:50 AM that he/she had his/her gown ripped off and was raped and beaten. The investigation revealed a written statement from Geriatric Nursing Assistant (GNA) #40 that documented on 5/27/26 at around 9:30 AM Resident #17 told her that another resident tried to rape him/her last night. There was no evidence that GNA #40 immediately told administration about the allegation. Continued review of the facility's investigation revealed the initial report was not filed until 5/27/26 at 12:43 PM, which was past the 2 hours for initial reporting. Additionally, the facility could not produce documentation that the final 5-day report was sent to OHCQ. On 7/9/26 at 9:45 AM an interview was conducted with Licensed Practical Nurse (LPN) #22 who stated that she did not know about the incident until the Director of Nursing (DON) called her up to ask her about it. LPN #22 stated that she worked the whole shift and was shocked that the GNA did not say anything to her. On 7/9/26 at 1:07 PM the DON stated that the previous DON and Nursing Home Administrator (NHA) were not following the process of sending the 5-day report and investigation to the regional team, therefore no follow-up could happen to ensure that the reports were sent timely to OHCQ.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of complaints, medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 3 (Residents #16, #24, #17) of 28 residents reviewed during a complaint survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 7/7/26 at 9:20 AM a review of facility reported incident 3044112 and Resident #16's medical record was conducted. Review of a 5/29/26 at 7:35 AM nurse's note documented, pt. refused a.m. lab. Review of a 5/30/26 at 13:49 (1:49 PM) behavior note documented, resident made several attempts to elope. Review of Resident #16's MDS assessment with an assessment reference date (ARD) of 5/31/26, Section E Behavior, coded none. This was incorrect as the resident rejected a blood draw for labs and made several attempts to elope. On 7/14/26 at 10:25 AM an interview was conducted with the MDS Coordinator. The MDS coordinator stated that she could not log into the computer system so she would have the regional MDS coordinator check for her. On 7/14/26 at 11:36 AM the MDS Coordinator confirmed the errors. 2) On 7/8/26 at 11:54 AM a review of complaint 2749436 and Resident #24's medical record was conducted. Review of Resident #24's admission assessment dated [DATE] documented that Resident #24 had an ileostomy. An ileostomy is a surgical procedure that diverts stool out of the body by connecting the lower part of the small intestine to an opening in the abdominal wall called a stoma. Stool is then collected in an external pouch. Review of Resident #24's quarterly MDS assessment with an assessment reference date (ARD) of 6/12/26, Section H0400 bowel continence, was coded (2) frequently incontinent. That was incorrect as it should have been coded as not rated due to having an ileostomy. Continued review of the quarterly MDS, section J, documented that the resident did not receive any pain medications during the look back period. In Section N, High-Risk Drug Classes, medications, it was coded that the resident did receive a hypnotic but not a diuretic medication. Review of Resident #24's June 2026 Medication Administration Record (MAR) revealed the resident received Gabapentin 100 mg (2) 3 times per day for neuropathic pain. Additionally, the MAR failed to produce documentation that Resident #24 received a hypnotic medication. The June 2026 MAR however did document that the resident received a diuretic medication which was Lasix. Section N in the MDS assessment failed to capture the diuretic medication. The MDS assessment also coded that the resident received a hypnotic medication when the resident did not. On 7/14/26 at 11:36 AM the MDS Coordinator confirmed the errors. 3) On 7/9/26 at 8:55 AM a review of facility reported incident 3025308 and Resident #17's medical record was conducted. Review of Resident #17's May 2026 MAR documented the use of the hypnotic medication Ramelteon every night. Review of Resident #17's MDS assessment with an ARD of 5/14/26, Section N Medications, N0415, High-Risk Drug Classes, failed to capture the use of the hypnotic. On 7/14/26 at 11:36 AM an interview was conducted with the MDS Coordinator who confirmed the errors.		

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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 record review, observation, and interview, it was determined that facility staff failed to administer medications in accordance with nursing practice standards. This was evident for 1 (Resident #6) of 16 residents reviewed for facility reported incidents during a complaint survey. The findings include: On 7/14/26 at 9:24 AM a review of facility reported incident 2968971 and Resident #6's medical record was conducted. Review of a 4/30/26 nurse practitioner (NP) progress note documented that Resident #6 had cognitive decline that was worsening and likely had frontal temporal dementia. Frontotemporal dementia is a group of progressive brain disorders that damage the frontal and temporal lobes of the brain. Review of Resident #6's most recent BIMS (Brief Interview of Mental Status) dated 6/15/26 was 6. A score of 6 falls into the lowest tier, which indicates severe cognitive impairment or problems with thinking and memory. On 7/14/26 at 11:55 AM the surveyor went to visit Resident #6 and observed Resident #6 lying in bed. Resident #6 appeared confused and was holding a 30 ml. plastic medication cup that contained 3 white pills. Three other pills were observed lying on the resident's chest. Two of the 3 pills were broken in half. On 7/14/24 at 12:23 PM a review of Resident #6's July 2026 Medication Administration Record (MAR) documented the medication that Resident #6 had in the medicine cup and on top of his/her chest. They were the 9 AM medications: Lasix (diuretic), (2) potassium tablets, carvedilol (blood pressure and heart failure) to be received twice per day, duloxetine (antidepressant), and buspirone (anti-anxiety) to be received twice per day. The Director of Nursing (DON) was called to the resident's room after the observation and confirmed the findings. The DON confirmed the standard of nursing practice was the nurse was to stay with the resident, especially with the resident's cognitive status, and observe that the resident had taken all of the medication when administered. The DON stated the nurse was not to leave any medication at the bedside.		

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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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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on review of a complaint, medical record review, and interview, it was determined that the facility failed to ensure that residents requiring dental services on a routine or emergent basis receive necessary or recommended dental services in a timely manner. This was evident for 1 (Resident #21) of 28 residents reviewed for complaints during a complaint survey. The findings include: On 7/10/26 at 8:11 AM a review of complaint 2976233 was conducted and alleged that Resident #21 had not received needed dental care. On 7/10/26 at 8:11 AM Resident #21's medical record was reviewed and revealed a 4/24/26 at 16:35 (4:35 PM) change in condition note that documented that the resident complained of pain in the left side of the mouth. The physician was called and ordered an antibiotic and a dental consult. A review of a 5/1/26 physician's progress note documented the reason for the visit was a follow-up for dental pain status. The physician documented that the resident completed the antibiotic that was prescribed for left tooth pain. The physician documented, Dental consult was ordered. Awaiting dental evaluation for definitive care. A review of a 6/15/26 nurse practitioner (NP) note documented the reason for the consult as, Management of antibiotics for tooth infection. The note stated, Reports tooth ache is improving. However, expressed frustration of not able to see the dentist. The NP documented, Possible dental infection. Will need to follow up with dentist for source control. On 7/10/26 at 9:01 AM the complainant was interviewed and stated, Has never seen a dentist. They overlook doctor's appointments. On 7/10/26 at 9:20 AM Resident #21 was interviewed and stated, I have not seen the dentist. On 7/10/26 at 10:09 AM Licensed Practical Nurse (LPN) #9, the unit manager was interviewed and stated that the resident was supposed to be seen through a certain vendor, but the resident's insurance got dropped and the resident did not have insurance. LPN #9 stated, we have been trying to set it up through the [name of vendor] for dental. We used to have somebody that makes the appointments, but they let that person go and the unit manager has to make the appointments now. LPN #9 stated that the business office was responsible for obtaining the insurance through the state. On 7/10/26 at 11:08 AM the business office manager (BOM) #30 was interviewed and stated they had issues with his/her insurance. She stated that Medicaid was approved at the end of October 2025, and the resident could see any specialty services. BOM #30 stated that staff were aware and there was no reason that he/she should not have been seen by the dentist. I was not aware that the appointments were not scheduled. On 7/10/26 at 1:35 PM the issue was discussed with the Director of Nursing (DON) and she confirmed the findings and stated that they would get the dental appointment made.		

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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 complaint, medical record review, and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 3 (Residents #21, #6, #35) of 34 residents reviewed for complaints during a complaint survey. The findings include: A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. 1) On 7/10/26 at 8:11 AM a review of complaint 2976233 alleged that Resident #21 had not been seen by the podiatrist or the ophthalmologist in over one year. Review of Resident #21's medical record failed to produce any evidence that the resident was seen by podiatry or ophthalmology. On 7/10/26 at 12:25 PM the Director of Nursing (DON) was interviewed and stated that they were in the process of having a new person upload all documents into the electronic medical record. On 7/10/26 at 12:35 PM Licensed Practical Nurse (LPN) #9 stated that Resident #21's chart was thinned. LPN #9 stated that the records should have been scanned into the system, but at the time of the visits they did not have someone in medical records, but now they did. On 7/10/26 at 1:35 PM the DON was able to find some of the documents to validate Resident #21 was seen by podiatry and ophthalmology. She did confirm that the documents should have been scanned into the medical record. 2) On 7/14/26 at 9:24 AM a review of facility reported incident 2968971 and Resident #6's medical record was conducted. Resident #6 had alleged abuse. Review of Resident #6's medical record revealed a 3/30/26 at 12:21 PM care plan note that documented the resident reported being thrown against the wall and held down while the Geriatric Nursing Assistant (GNA) forcefully changed his/her brief. Review of a 4/30/26 nurse practitioner (NP) progress note documented that Resident #6 had cognitive decline that was worsening and likely had frontal temporal dementia. On 7/14/26 at 11:55 AM the surveyor went to visit Resident #6 and observed Resident #6 lying in bed. Resident #6 appeared confused and was holding a 30 ml. plastic medication cup that had 3 white pills in it. There were 3 other pills lying on top of the resident's chest. Two of the 3 pills were broken in half. On 7/14/24 at 12:23 PM a review of Resident #6's July 2026 Medication Administration Record (MAR) (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented the medication that Resident #6 had in the medicine cup and on top of his/her chest. They were the 9 AM medications: Lasix (diuretic), (2) potassium tablets, carvedilol (blood pressure and heart failure) to be received twice per day, duloxetine (antidepressant), and buspirone (anti-anxiety) to be received twice per day. The medications were not signed off as administered at 12:23 PM. Review of the Administering Medications Policy that was given to the surveyor on 7/14/26 at 12:39 PM revealed #20; the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. The DON was called to the resident's room after the observation and confirmed the findings. The DON was informed that the resident's MAR was not signed. 3) On 7/20/26 at 11:30 AM, a review of complaint #3094426 and Resident #35's medical record was conducted. Resident #35 experienced a respiratory distress event and was transferred to the hospital per responsible party's (RP) request. Review of Resident #35's medical record revealed a Late Entry Change in Condition note with an effective date of 7/14/26 at 11:00 AM, created on 7/15/26 at 12:09:06 PM by Licensed Practical Nurse (LPN) #46, the assigned nurse for Resident #35. The note documented the resident experienced respiratory distress and was transferred to the emergency department. During the complaint investigation, an interview with the complainant on 7/20/26 identified LPN #44 as the nurse who initially responded to Resident #35's respiratory distress and notified the hospice team. On 07/20/26 at 1:41 PM, an interview with LPN #44 revealed Unit Manager (UM) #9 and Registered Nurse (RN) Night Supervisor #45 also responded to Resident #35's respiratory distress event. Interviews with UM #9 and RN Night Supervisor #45 on 7/22/26 confirmed the interventions they performed during Resident #35's respiratory event included elevating the head of the bed, discontinuing the tube feeding, performing oral suction, administering oxygen via non-rebreather mask, notifying the hospice team, and coordinating the resident's emergency response. Review of Resident #35's medical record failed to include complete documentation of the nursing assessments and interventions performed by staff who initially responded to Resident #35's respiratory distress documented in the medical record. On 7/23/26 at 9:43 AM, during an interview, the Director of Nursing (DON) was made aware of concerns regarding the lack of documentation. The DON confirmed there was no additional nursing documentation in PointClickCare (PCC), the facility's electronic medical record, related to the responding staff's interventions during Resident #35's respiratory distress event. The DON further stated each staff member who intervened should have documented how the resident was found and the care they provided. The DON stated she would follow up with the responding staff. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Change in a Resident's Condition or Status policy on 7/24/26 revealed, under Policy Interpretation and Implementation, Item #8, The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. On 7/24/26, during a follow-up interview, the DON stated all staff who intervened during Resident #35's respiratory distress event should have documented the care they provided in the medical record, and the documentation should not have been left to the assigned nurse alone . The DON stated UM #9 believed LPN #46, the assigned nurse, would document the event. The DON subsequently provided written statements from UM #9 and RN Night Supervisor #45 describing their involvement in Resident #35's care on 7/14/26. The statements described interventions, including discontinuation of the tube feeding, oral suctioning, oxygen administration via non-rebreather mask, and coordination of the resident's emergency response, which were not documented in the medical record.		