FOIA Data Base - The Law Office of Jeffrey J. Downey, serving clients in Washington D.C., Virginia and Maryland

If you have been injured in a nursing home or assisted living facility, call the Law Office of Jeffrey J. Downey for a free consultation.

Phone: 703-564-7318; email: jdowney@jeffdowney.com

Crofton Convalescent Center
2131 Davidsonville Road
Crofton, MD 21114

Characteristics:

- For-Profit Corporation with 180 beds
- Legal Business Name – Crofton Convalescent Center Inc
- Administrator – Philip J Gordon, Sr.
- www.croftoncrc.com

Crofton Convalescent Center is listed as a Five-Star Facility, according to Medicare.gov

Researching Nursing Homes

A note by attorney Jeffrey J. Downey:

Thank you for visiting my website. Anyone who is considering the admission of a loved one into a nursing home or an assisted living facility should undertake a review of surveys or other data that will provide a snapshot of some of the issues or problems that the facility is experiencing. Keep in mind that this information can be limited and may not reflect the actual condition of the facility when your loved one is admitted. You should consider personal visits of any facility you are evaluating.

The Maryland Department of Health inspects nursing homes including the Crofton Convalescent Center in Crofton, MD. Periodically they do inspections as complaint surveys which should be public record.

I am interested in any additional information you may have on this facility. Please call me with any question about this or any other facility you may be interested in searching or prosecuting civilly for patient neglect or abuse.

If you have a concern or complaint about a nursing home or an assisted facility, there are three ways to file your complaint:

1) Write to the Maryland Department of Health, Office of Health Care Quality, 7120 Samuel Morse Drive, Second Floor, Columbia, MD 21046-3422. (linkhttps://health.maryland.gov/ohcq/docs/complaint_form.pdf)

2) Fax : 410-402-8179

3) Online - https://fs30.formsite.com/OHCQ/OnlineComplaintForm/index.html

Having already researched Crofton Convalescent Center in Crofton, MD and obtained FOIA responses, I am posting these statements of deficiencies here, in a searchable format. Keep in mind that these surveys have been altered during the conversion process and you should update your search results.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215120	A. Building B. Wing	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crofton Convalescent Center	2131 Davidsonville Road Crofton, MD 21114

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 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 medical record review and staff interview, it was determined the facility staff failed to maintain a medical record in the most accurate form for a resident (#1). This was evident for 1 of 3 residents reviewed for accurate medical records during the complaint survey. The findings include: A medical record is the official documentation for 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. [NAME]land Medical Orders for Life-Sustaining Treatment (MOLST) is a portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments. The medical orders are based on a resident's wishes about medical treatments. On 12-12-19 at 9:14 AM while reviewing Resident #1's medical record this surveyor found 2 active MOLST forms. One was dated and active with a practitioner's signature as of 6-5-15 and besides a complete front page, the 1-9 options sections of page 2 were completed. The second MOLST dated and active with a practitioner's signature as of 6-9-15 had only the front page completed and not options 2 through 9. Resident #1's medical record was reviewed with the Director of Nursing (DON) on 12-19-19 at 10:35 AM and it was confirmed that 2 active MOLST forms were a part of the active medical record. The DON verbalized that she understood that only one MOLST order form is to be in the medical record and that the MOLST form not active is to have a line drawn through it with void written on it. An interview on 12-19-19 at 11:22 AM with the Assistant Nursing Home Administrator, the DON and the Administrator in Training confirmed that Resident #1's medical record had 2 active MOLST forms. Each verbalized an understanding that Resident #1 can only have one active MOLST order and all others are to have the word void written and one line drawn on the front.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215120	A BUILDING _____ B WNG _____	07/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE, ZIP CODE
CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MD 21114

(X<I)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(I\$1 COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted at this facility on 7/17/20 and 7/20/20, by the Office of Health Care Quality to investigate complaint MD00155031. Surveyors conducted onsite survey activities on 7/17/20. The licensed bed capacity for this facility is 180 Comprehensive Care Facility (CCF) beds, the resident census at the start of the survey was 121, and there were 6 residents included in the sample Survey activities consisted of a review of medical records, facility documentation, interviews with staff, and observations of resident and staff practices. Administrative reports and facility policies and procedures were, also, reviewed. The facility was in substantial compliance with 42 CFR §483.80 (Infection Control), Subpart-B-Requirements for Long Term Care Facilities. This survey also did not identify non-compliance with Federal and State requirements that were reviewed in relationship to complaint MD00155031. COVID-19 (Coronavirus Disease 2019), is a disease caused by the coronavirus SARS -CoV-2. COVID-19 spreads from person to person, mainly through respiratory droplets produced when an infected person coughs or sneezes.	F000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE ITU (Xe) DATE

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	215120	A BU I L D I NG _____ B W NG _____	07/20/2020

NAM€ OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE, ZIP CODE
CROFTON CONVALESCENT CENTER	2131 DAV1DSONV1LLE ROAD CROFTON, MD 21114

(X4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	to PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X$) COMPLETION DATE
E 000	InItIal Comments A COVID-19 Focused Emergency Preparedness Survey was conducted by the Office of Health Care Quality as part of the Focused Infection Control Survey at this facility on 7/17/20 and 7/20/20 . The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6).	EOOO		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE ITLE ()C&) DATE

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Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215120	A. BUILDING:_____ B. W NG _____	07/20/2020

NAME OF PROVIOER OR SUPPLIER	STREET ADDRESS, CITY STATEZIP CODE
CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MD 21114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES {EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S000	Initial Comments A COVID-19 Focused Infection Control Survey was conducted at this facility on 7/17/20 and 7/20/20, by the Office of Health Care Quality to investigate complaint MD00155031. Surveyors conducted onsite survey activities on 7/17/20. The licensed bed capacity for this facility is 180 Comprehensive Care Facility (CCF) beds, the resident census at the start of the survey was 121, and there were 6 residents included in the sample. Survey activities consisted of a review of medical records, facility documentation, interviews with staff, and observations of resident and staff practices. Administrative reports and facility policies and procedures were, also, reviewed. The facility was in substantial compliance with 42 CFR §483.80 (Infection Control), Subpart-8-Requirements for Long Term Care Facilities. This survey also did not identify non-compliance with Federal and State requirements that were reviewed in relationship to complaint MD00155031. COVID-19 (Coronavirus Disease 2019), ts a disease caused by the coronavirus SARS -CoV-2. COVID-19 spreads from person to person, mainly through respiratory droplets produced when an infected person coughs or sneezes.	S 000		

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STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLECONSTRUCTION	(X3I DATE SURVEY COMPLETED
	215120	A. BUILDING _____ B. WING _____	R-C 02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE, ZIP COOE
CROFTON CONVALESCENT CENTER	**2131 DAVIDSONVILLE ROAO CROFTON, MD 21114**

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{F 000}	INITIAL COMMENTS On January 8, 2020, an off-site survey was conducted to review the facility's plan of correction for deficiencies that were cited during the survey ending December 20. 2020. Survey activities included the review of the facility's plan of correction and credible evidence. Effective January 8, 2020, the facility was determined to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	{F 000}		

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Office of Health Care Quality

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CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MD 21114

(X| ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OFPROVIDER OR SUPPLN:R	STREET ADDRESS, CITY, STATE, ZIP CODE
CROFTON CONVALESCENT CENTER	**2131 DAVIDSONVIUE ROAD CROFTON, MD 21114**

(X4) 1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 000	INITIAL COMMENTS	FOOO		

On February 4, 2020, a compliant survey was conducted at this facility by the Office of Health Care Quarity to investigate complaint #MO00150966. Activities included the audit of the residents' personal funds records maintained by this facility.

The complaint was unsubstantiated. This survey did not identify noncompliance with Federal requirements that were reviewed in relationship to the complaint

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Office Of Health Care Quality

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	215120	A. BUILDING:_____ B WING _____	C 02/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY STATEZJP CODE
CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MD 21114

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S000	Initial Comments On February 4, 2020 . a compliant survey was conducted at this facility by the Office of Health Care Quality to investigate complaint #MD00150966. Activities included the audit of the residents' personal funds records maintained by this facility. The complaint was unsubstantiated. This survey did not identify noncompliance with State requirements that were reviewed in relationship to the complaint.	S000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6)0ATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROFTON CONVALESCENT CENTER	**2131 DAVIDSONVILLE ROAD CROFTON, MD 21114**

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F 000	INITIAL COMMENTS On December 19, 2019 and December 20, 2019 a complaint survey was conducted at this facility which has a bed capacity of 180 and a census of 161 by the Office of Health Care Quality to investigate complaints MD00140522, MD00146095 and MD00148492 and facility reported incidents MD00143306. Investigative activities included the review of 3 resident medical records, interviews of staff and residents, observation of resident and staff practices, and review of facility investigations. This survey did identify noncompliance with Federal or State requirements that were reviewed in relationship to complaint MD00140522.	F000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. {i) A facility may not release information that is resident-identifiable to the public. (ii) The facility *may* release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to doso. §483.70{i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 842		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | ()(6) OATE 01/29/2020

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MO 21114

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F 842	Continued From page 1 **(iv)** Systematically organized §483.70(1)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (1) To the individual, or their resident representative where permitted by applicable law: {ii) Required by Law; (iii) For treatment. payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F 842		

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F 842	Continued From page 2 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the facility staff failed to maintain a medical record in the most accurate form for a resident (#1). This was evident for 1 of 3 residents reviewed for accurate medical records during the complaint survey. The findings include: A medical record is the official documentation for a healthcare organizatio.n 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. Maryland Medical Orders for Life-Sustaining Treatment {MOLST) is a portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments. The medical orders are based on a resident's wishes about medical treatments. On 12-12-19 at 9:14 AM while reviewing Resident #1's medical record this surveyor found 2 active	F 842		

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NAME Of PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE, ZIP CODE
CROFTON CONVALESCENT CENTER	**2131 DAVIDSONVILLE RO.AO** CROFTON, MD 21114

(X4) 10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYINGINFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVIE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 3 MOLST forms. One was dated and active with a practitioner's signature as of 6-5-15 and besides a complete front page, the 1-9 options sections of page 2 were completed. The second MOLST dated and active with a practitioner's signature as of 6-9-15 had only the front page completed and not options 2 through 9. Resident #1's medical record was reviewed with the Director of Nursing (DON) on 12-19-19 at 10:35 AM and it was confirmed that 2 active MOLST forms were a part of the active medical record. The DON verbalized that she understood that only one MOLST order form is to be in the medical record and that the MOLST form not active is to have a line drawn through it with "void" written on it. An interview on 12-19-19 at 11:22 **AM** with the AssistantNursing Home Administrator, the DON and the Administrator in Training confirmed that Resident #1's medical record had 2 active MOLST forms. Each verbalized an understanding that Resident #1 can only have one active MOLST order and all others are to have the word void written and one line drawn on the front.	F842		

Office of Health Care Quality

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CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MD 21114

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S1370	10.07.02.32 A Clinical Records .32 Clinical Records. A. Records for all Residents. Records for all residents shall be maintained in accordance with accepted professional standards and practices. This Regulation is not met as evidenced by: Refer to CMS 2567, F842.	S1370		

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LABORATORY DIRECTOR"S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/29/20

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PI.AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	{X3) DATE SURVEY COMPLETED
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CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MD 21114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
S 0001	Initial Comments On December 19, 2019 and December 20, 2019 a complaint survey was conducted at this facility which has a bed capacity of 180 and a census of 161 by the Office of Health Care Quality to investigate complaints MD00140522, MD00146095 and MD00148492 and facility reported incidents MD00143306. Investigative activities included the review of 3 resident medical records, interviews of staff and residents, observation of resident and staff practices, and review of facility investigations This survey did identify noncompliance with Federal or State requirements that were reviewed in relationship to complaint MD00140522.	**S000**		
S1370[	10 .07.02.32A Clinical **Records** .32 Clinical Records. A Records for all Residents. Records for all residents shall be maintained in accordance with accepted professional standards and practices. This Regulation is not met as evidenced by: Refer to CMS 2567, F842.	S1370		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6jOATE 01/29/20

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21512D	A BUILDING:_____ B WNG _____	R 05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE. ZIP COOE
CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MD 21114

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{S 0001 Initial comments	On April 26, 2019, an off-site survey was conducted by the Office of Health Care Quality related to deficiencies cited on the annual Medicare/Medicaid survey conducted from March 19, 2019 through March 25, 2019. Survey activities included the review of the facility's plan of correction and credible evidence. Effective April 26, 2019, the facility was determined to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	{S 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) CATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215120	A. BU I LDNG _____ B. IMNG _____	R 05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MD 21114

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{F 000}	INITIAL COMMENTS On April 26, 2019, an off.site survey was conducted by the Office of Health Care Quality related to deficiencies cited on the annual Medicare/Medicaid survey conducted from March 19, 2019 through March 25, 2019. Survey activities included the review of the facility's plan of correction and credible evidence. Effective April 26, 2019, the facility was determined to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Tenn Care Facilities.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (MI OA.T£

Any deficiency statement ending with an asterisk (') denotes a deficiency which the Institution may be excused from correcting providrng it is determined that other safeguards provide sufliaent protection lo the patients {See instructions) Except for nursing homes, the findings stated above are disctosable 90 days following the date of survey whether or not a plan of oorrection is provided. For nursmg homes. the above findings and plans of COO'eciion are disclosable 14 days following the date these documents are made available to the facility If deficiencies are o ted, an approved plan of correction is requisite to continued program participation.

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215120	A. BUILDING _____ B \II/ING _____	03/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MD 21114

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial comments On March 19,2019 through March 25, 2019 an annual Medicare/Medicaid Long Term Care survey for recertification was conducted by the Office of Health Care Quality. The facility's licensed bed capacity is 180 Comprehensive Care Facility (CCF) beds and the census in the initiation of the survey was 161 CCF beds. The survey sample consisted of 40 residents in the investigative part of the survey. Survey activities consisted of the review of medical records, interviews with residents, facility staff and family members. Also, observations and staff practices were reviewed, as well as, the policies and procedures. Additionally, there were 5 facility reported incidents investigated during the survey: #MD00136476 was unsubstantiated with no deficiencies. #MD00136714 was unsubstantiated with no deficiencies, #MD00128550 was unsubstantiated with no deficiencies, #MD00127923 was unsubstantiated with no deficiencies and #MD 00125757 was unsubstantiated with no deficiencies. The Nursing Home Administrator and the Director of Nursing were notified of the findings during the exit conference.	S000		
S 320! 10.07.02.08 E Admission and Discharge	.08 Admission and Discharge E. Notification of Responsible Persons VVhen Patient Moves. The administrator or the administrator's designee shall notify the private or	S 320		

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	[X3) DATE SURVEY COMPLETED
	215120	A. BUILDING _____ B. \/\ANG _____	03125/2019

NAME Of PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE. ZJP CODE
CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MD 21114

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S 320	l Continued From page 1 public agency or relative responsible for the patient when the patient is transferred from the facility for any reason or at time of death. The attending physician shall also be notified. This Regulation is not met as evidenced by: Refer to CMS 2567 F Tag 623	S320		
S510	10 .07.02.12 Q Nsg Svcs;Charge Nurse .12 Nursing Services. Q. Charge Nurse. At least one licensed nurse shall be on duty at all times and shall be designated by the director of nursing to be in charge of the nursing activities during each tour of duty. The charge nurse or nurses shall have the ability to recognize significant changes in the condition of patients and to take necessary action. This Regulation is not met as evidenced by: See F-Tag 0761	S 510		
S 512	10.07.02.12 R Nsg Svcs: Charge Nurse Daily Rounds .12 Nursing Services. R. Charge Nurses' Daily Rounds . The charge nurse or nurses shall make daily rounds to all nursing units for which **responsible,** performing such functions as: {1) Visiting each patient: (2) Reviewing clinical records, medication orders,	S512		

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADORESS, CITY. STATE ZIP COOE
CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MD 21114

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S 512	Continued From page 2 patient care plans, and staff assignments; (3) To the degree possible, accompanying physicians when visiting patients. This Regulation is not met as evidenced by: Refer to CMS 2567 F tag 880	S 512		
S1175	10.0 7.02.23 Transfer Agreement .23 Transfer Agreement. A. Written Agreement. A written agreement with at least one acute hospital shall be effected which shall provide for the following actions: (1) Planning to ensure that all services required for the continuity of patient care will be made available promptly; (2) Advance discussion with the patient regarding the reason for the transfer and any available alternatives; (3) Notification to the next of kin or responsible person regarding the anticipated transfer; (4) Interchange of medical and other information necessary in the care and treatment of patients transferred between the facilities; (5) nmely admission to the hospital when the attending physician determines acute hospital care is medically appropriate; (6) Safe transportation and care of the patient during transfer; (7) Security and accountability for the patient's personal effects; (8) Prompt readmission to the comprehensive care facility or the extended care facility at the end of the hospital stay (when program fiscal controls permit);	S1175		

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STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA 1DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	{X3) DATE SURVEY COMPLETED
	215120	A. BUILDING:_____ B. \II/ING _____	03/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE. ZIP CODE
CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MD 21114

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S1175	Continued From page 3 (9) Annual review of execution of transfer arrangements (by utilization review committee or other designated group) to assure that each party is fulfilling the needs of both the patients and the providers (the hospital and the comprehensive care facility or the extended care facility); (10) If needs are not being met, it is the responsibility of the administrator of the comprehensive care facility or the extended care facility to act on recommendations of the reviewing group and to effect compliance; (11) Before licensure, the comprehensive care facility or the extended care facility shall submit to the Department a copy of the written agreement, signed by persons authorized to execute the agreement on behalf of the facilities; (12) Each facility shall maintain a signed copy of the agreement. B Facilities Under Common Control. If two facilities are under common control, a written agreement is not required; policies and procedures of both facilities shall provide assurance that § A(1)-(12) will be the practice of the facilities. C. Exception for Comprehensive Care Facility. If a comprehensive care facility is unable to effect a transfer agreement with a hospital in the community and can document its attempts to secure an agreement, the facility shall be considered to have such an agreement in effect. Agency Note: It is recommended that the comprehensive care facility arrange for a similar transfer agreement with an extended care facility. This Regulaiton is not met as evidenced by: Refer to CMS 2567	81175		

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MD 21114

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S1175	Continued From page 4 F Tag 625	S1175		
S5090	10.07.09.08 A Res Rights/Svcs;general .08 Resident's Rights and Services. **A. A** nursing facility shall provide care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, and in full recognition of the resident's individuality. This Regulation is not met as evidenced by: See F tag 0550	S5090		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAl' SE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNF. AND NF.	PROVIDER# 215120	MULTIPLE CONSTRUCTION A BUILDING_____ WING _____	DATE SURVEY COMPLETE 3/25/2019
NAME OF PROVIDER OR SUPPLIER **CROFTON CONVALESCENT CENTER**	STREET ADDRESS. CITY. STATE. ZIP CODE **2131 DAVIDSONVILLE ROAD CROFTON.MD**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F62J	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483. \5(c)(3) Notice before transfer. Before a facility transfers or discharges a resident. the facility must- (i) Notify the resident and the resident's rcpresentative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section: and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483. I 5(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(S) of this section. the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge whcn- (A) The safety of individuals in the facility would be endangered under paragraph (c)(l)(i)(C) of this section; (B) The health of individuals in the facility would be endangered. under paragraph (c)ll)(i)(D) of this section: (Cl The resident 's health improves sufliciently to allo\, a more immediate transfer or discharge. under paragraph (c)(I **)(i)(B)** of this section: (0) An immediate transfer or discharge is requ ired by the resident's urgent medical needs. under paragraph (c}(l)(i)(A) of this section: or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specitied in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge: (ii) The ellective date of transfer or discharge: (iii)) The location to which the resident is transferred or discharged: (iv) A statement of the resident 's appeal rights. including the name. address (mailing and email). and telephone number of the entily which receives such requests: and information on how to obtain an appeal form and assistance in complel ing the form and submitting the appeal hearing request: (\} The name. address (mailing and email) and telephone number of the Ollice of the State Long-Term Care Ombudsman: (vi) For nursing facility residents with inlellectual and developmental disab ilities or related disabilities. the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402. codified at 42 U.S.C. 15001 et seq.): and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email

Any deficiency :s,u.tement e nd•ns with an astensk r) denotes.a deficiency whic h the 1ns.11ur1on may be eii;cused from -correcting pl0\.1dmn 1t ls detemnn ed 1hat other safeguards pro„ de sullic,ent proiecuon to the pauenu (See msuu.:tions. > f)Cce pt for nursing homes. the findings stated above are d1sclosable 00 days following the date of sUl"\ey whether or not a pion of rorreci t0n ,s pro...·,ded For nuf'img hom . the abo'tle- find•nss and plans of corrcctton are dl:S(:losable I-I da:i;:s following. the date these documents a.-e made a\ a,lable1o 1he fac:1hr,.· If defic1encECS are cited. an .approved

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE 1';0 HARM WITH ONLY A POTEJ\,'TIAL FOR MINIMAL HARM FOR SNFo AND Nfo	PROVIDER II 215120	MULTIPLE CONSTRUCTION A BU i DiNG _ _ _ _ _ _ _ B WING _____	DATE SURVE\ ' COMPLETE J/2512019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE. ZIP CODE
CROFTON CONVALESCENT CENTER	**2131 DAVIDSON\'ILLE ROAD CROFTON.MD**

ID PREFIX TAG	SUMMAR\' STATEMENT OF DEFICIENCIES
F623	Contmued From Page I

address and telephone number of the agency responsible for the protection and advocacy of individuals nith a mental disorder established under the Protection and Advocacy for Mentall)· 111 lndh iduals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to elTecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure. the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents oflhc facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents. as required at § 483.70(1).
This REQUIREMENT is not met as evidenced by:
Based on the medical record and facility interviews, it was determined that the facilit} staff failed to provide written notice to Resident #117 and the resident's Responsible Party. ofa transfer out of the facility. This was evident for I out of 40 residents investigated during the survey process.

The findings include:

On 03/25119 around 01:42 PM. Res ident # 117's medical record was revie\\ed for a recent hospitalization. On - the resident was found unres ponsive \\ith a blood pressure {BP) of 64/44.1be doctor ordered that the resident be sent out lo the hospital. During further revie\ of the medical record. it was noted that there \\os no documentation that a written notice was given lo the resident, and the Responsible Part) (RP) regarding the reason for the resident's hospitalization

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1I PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	216120	A BUILDING _____ IMING _____	03/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE, ZIP CODE
CROFTON CONVALESCENT CENTER	**2131 DAV1DSONV1LLE ROAD CROFTON, MD 21114**

(X4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(I<&) CO MPLETION DATE
F 000	**INITIAL COMMENTS** On March 19,2019 through March 25, 2019 an annual Medicare/Medicaid Long Term Care survey for recertification was conducted by the Office of Health Care Quality. The facility's licensed bed capacity is 180 Comprehensive Care Facility (CCF) beds and the census in the initiation of the survey was 161 CCF beds. The survey sample consisted of 40 residents in the investigative part of the survey. Survey activities consisted of the review of medical records, interviews with residents, facility staff and family members. Also, observations and staff practices were reviewed, as well as, the policies and procedures. Additionally, there were 5 facility reported incidents investigated during the survey: #MD00136476 was unsubstantiated with no deficiencies, #MD00136714 was unsubstantiated with no deficiencies, #MD00128550 was unsubstantiated with no deficiencies, #M000127923 was unsubstantiated with no deficiencies and #MD 00125757 was unsubstantiated with no deficiencies. The Nursing Home Administrator and the Director of Nursing were notified of the findings during the exit conference.	FOOC		
F 550 SS=O	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and	F550		

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04/26/2019

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE, ZIP CODE
CROFTON CONVALESCENT CENTER	2131 0AVI0SONVILLE ROAD CROFTON, MD 21114

(X4) 1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYINGINFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACHCORRECTIVE ACTIONSHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X51 COMPLETION OATE
F 550	Continued From page 1 access to persons and services inside and outside the facility, including those specified in this section. §483.10{a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a){2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition. or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b)Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1)The facility must ensure that the resident can exercise his or her rights without interference, coercion, discriminatio,nor reprisal from the facility. §483.10(b)(2)The resident has the right to be free of interference, coercion, discrimination,and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on an interview with family member, who	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X21MULTIPLE CONSTRUCTION	(X31DATE SURVEY COMPLETED
	215120	A BUILDING _____ B \IVNG _____	03/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE, *ZIP* CODE
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F 550	Continued From page 2 is the responsible party and the residen,t the facility failed to honor the family whishes to change the bed linen of the resident in a timely manner. This was evident for 1 out of 1 resident (R#292) reviewed. Findings Include: On 3/19/19 at 12:58 PM an interview was conducted with Resident # 292's daughter who is also the Responsible Party (RP). the daughter stated that on 3/18/19 she noticed a large amount of blood and drainage coming from fracture site. She asked the nurse to come in and check the dressing and to change the bed linen as it was quite soiled. This occurred during the afternoon of 3/18/19. The resident's linen was not changed until after 6 PM that evening. On the day of the interview with the surveyor on 3/19/19 at 12:58 PM, Resident# 292's daughter again asked the Geriatric Nursing Assistant, staff #4, at 8 AM to change her (Resident# 292) bed linen. as there was some body fluid stain on the sheet. The daughter said that the GNA said nothing to her and has not gone into the room since. On 3-19-19 at 1 P.M. this surveyor spoke with the Unit Manager, staff #3, of the concern and showed the soiled linen to the Unit Manager. The Unit Manager spoke with the Geriatric Nursing Assistant (GN A), staff# 4. and asked her to change the linen now. The linen was changed and there were no other concerns.	F550		
F 625 SS=D	Notice of Beel Hold Policy Before/Upon Tmsfr CFR(s): 483.15(d)(1)(2)	F625		

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F625	Continued From page 3 §483.15(d) Notice of bed-hold policy and retum- §483.15(d)(1)Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration ofthe state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under§ 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods , which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on the medical record and staff interviews, the facility staff failed to provide required written notice for Resident # 117, orthe Resident's responsible party, of the bed hold policy during a transfer out of the facility. This was evident for 1 out of 1 residents investigated for hospitalization during the survey process.	F625		

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CROFTON CONVALESCENT CENTER	2131 0AVIDSONVILLE ROAD CROFTON, MD 21114

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI ATE DEFICIENCY)	(XS) COMPLETION OATE
F 625	Continued From page 4 The findings include: On 03125/19 around 01:42 **PM,** Resident#117's medical record was reviewed for a recent hosptialization. On the resident was found unresponsive with a blood pressure (BP) reading of 64/44. The doctor ordered that the resident be sent out to the hospital. Review of the hospital transfer information in the resident's chart did not reveal that a bed hold policy was given to the resident prior to leaving the building. This policy educates the resident on whether a bed can be held during the resident's absence, and or if not, the possibility of having to privately pay to hold the resident's bed, until the resident returns.	F625		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h}(1)(2) §483.45(9) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expirationdate when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F761		

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215120	A BUILDING _____ B WNG _____	03/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE, ZIP CODE
CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MD 21114

(X4) 10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 761	Continued From page 5 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation of medication storage room and medication carts on March 25,2019 the facility failed to date medications that were opened on station 3 front certified medication aid **(CMA)** medication cart. This was evident for 1 out of 8 medication carts looked at for compliance. The findings include: On 3/25/19 at 12:40 PM 4 medication storage rooms were checked for compliance and 8 medication carts. On station #3, The front CMA (Certified Medication Aid) cart had 4 residents who did not have the dates when the medication was opened : Resident# 10 was ordered erythromycin ointment for bilateral eyes for the diagnosis of Blipharistis. There was no date when the ointment was opened. Resident# 96 was ordered systane liquid opth. drops ordered for each eye for the diagnosis of glaucoma. There was no date indicating when the systane eye drops were opened. Resident# 47 was ordered Refresh eye drops, 1 drop in each eye 3 times per day. There was no	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215120	A BU I L D/ NG _____ B W NG _____	03/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, O TY. STATE. ZIP CODE
CROFTON CONVALESCENT CENTER	2131DAVIOSONVILLEROAD CROFTON, MO 21114

(X4)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY!	(X&) COMPU ; TION DATE
F 761	Continued From page 6 date when the Refresh eye drops were opened. Resident # 67 was ordered Lantanoprost opth. 1 drop in each eye for the diagnosis of glaucoma. There was no date when the Lantanoprost was opened. The Director of Nursing (DON) was present when the station 3 certified medication Aid cart was checked The DON took the medication involved and verified that there was no date listed when the medication was opened.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a)Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.7D(e) and following accepted national standards;	F 880		

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215120	A BUILDING _____ B 'MNG _____	03125/2019

NAME Of PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE, ZIP CODE
CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MD 21114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(115) COMPLETION D"TE
F 880	Continued From page 7	F880		

§483.80(a)(2)Written standards, policies. and procedures for the program, which must include, but are not limited to:
{i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstance.s
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food. if direct contact will transmit the disease: and
(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e)Linens.
Personnel must handle, store. process. and transport linens so as to prevent the spread of infection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	{X3) DATE SURVEY COMPLETED
	216120	A. BUILDING _____ B WING _____	03/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. $TATE. ZIP CODE
CROFTON CONVALESCENT CENTER	2131 DA\IIDSONVIIIE ROAO CROFTON, MD 21114

(X4)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X3) COMPLETION OATE
F 880	Continued From page 8 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program. as necessary. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility staff failed to use proper hand washing techniques prior to and after administering medications. This practice was observed during 3 times out of 4 residents observed during the medication pass. The findings inciude: On 03/25/19 during an observation of the morning medication pass, this writer witnessed staff #1 wash their hands with soap, under running water. The staff then was observed turning the faucet off with wet hands and not with a paper towel. Staff then proceeded to dry their hands and proceed to administer medications to the next resident. This was witnessed on two occasions for staff #1 during the medication pass. During the same medication pass observation, staff #2 was witnessed on 1 occasion, turning off the faucet with bare hands after passing medications to a resident. Both staff persons were informed of their error. Hand washing is one of the most effective ways to prevent the spread of germs from one person to another. Using a wet dean hand to turn off the faucet instead of a dry paper towel, transfer the genns from the faucet back to the hand. It is the facility's responsibility to protect its	f 880		

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	()(1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X21MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215120	A. BUILDING _____ B. WING _____	03/25/2019

NAME OF PROVIDER OR SUPPUER	STREET ADDRESS, CITY, STATE ZIP CODE
CROFTON CONVALESCENT CENTER	**2131 OAV1DSON\11LLE ROAD CROFTON, MO 21114**

(X4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE **ACTION** SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION OATE
F 880	F 880 Continued From page 9 residents from any possible contaminations.	F 880		

Office of Health Care Qualitv

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215120	A, BUILDING. _____ B. WING _____	12/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADORESS, CITY. STATE. ZIPCODE
CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MD 21114

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS> COMPLETE OATE
S000	Initial comments On December 28, 2018, a complaint investigation survey was conducted by the Office of Health Care Quality to investigate facility reported incident number MD00130359. The facility is licensed for 180 beds with an occupancy of 143 beds at the initiation of the survey. Survey activities consisted of a review of one (1) resident's medical records, interviews with residents and staff and observation of resident care and staff practices. It was determined that there were no deficiencies identified as a result of this investigation under the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	S 000		

OHCQ
LABORATORY DIRECTOR'S OR PROVIOER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN Of CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215120	A. BUILDING _____ B. lMNO_____	C 12/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE ZJPCODE
CROFTON CONVALESCENT CENTER	2131 DAVIDSONVJLLE ROAD CROFTON, MD 21114

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OHCQ
LABORATORY DIRECTOR'S OR PROVIOERISUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X&J DATE

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIERICLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215120	A BUILDING _____ B VIANG _____	C 12/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE, ZIP CODE
CROFTON CONVALESCENT CENTER	**2131 DAVIDSONVJLLE ROAD CROFTON, MD 21114**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	()($) COMPLETION OATE
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIve·s SIGNATURE | TITLE | (X8J **OATE**

Any deficiency statement ending with an asterisk 1•) denotes a deficiency wh,ch the institution may **be** excused from correcting providing it is determined that other safegu11rds provide sufficient protection to the patients (See instructions) Except for nursing homes, the findings stated above **are** disdOSllble 90 days following the date of survey whether or not a plan of correction 1s p rovided. For nursing homes. the **above** findings and plans of corredion are disclosable 14 days following **the date these** documents are made available to the facility. If deftciencies **are** cited , an approved plan of correction is requisite to continued program participation.

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215120	A. BUILDING _____ B 'MNG _____	R 01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY. STATE . ZIP CODE
CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MD 21114

(X4)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S ooc	Initial comments On January 12, 2018, an off-site survey was conducted by the Office of Health Care Quality related to deficiencies cited on the annual Medicare/Medicaid survey conducted from November 3, 2017 through November 9, 2017. Survey activities included the review of the facility's plan of correction and credible evidence. Effective November 9, 2017, the facility was determined to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	{S 000}		

OHCQ
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6)DATE

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	216120	A. BUILDING: _____ B. !MNG _____	R-C 01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MD 21114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6)0ATE

Office Qf Health Care Quality

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215120	A. BUILDING: _____ B. VYING_____	C 12/11/2018

NAME Of' PROVIDER OR SUPPLIER	STREET AOORESS, CITY, STATE ZIP CODE
CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MD 21114

(X4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST 8E PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S000	Initial comments On December 11, 2018, a limited environmental survey was conducted at this facility to detennine if the newly constructed rooms meet the State and Federal regulatory requirement for the resident use. The facility is lieensed for 180 beds at the time of the survey the census was 150. The survey activities included a tour of newly constructed rooms, medial storage, and an open area that residents can congregate in. This survey identified one complaint investigation that was reported, (MO00134224). There were no Federal or State deficiencies noted in the tour.	**S000**		

OHCO
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TtTLE (X6)DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X21MULTIPLE CONSTRUCTION	(X3J DATE SURVEY COMPLETED
	215120	A.BU I L D NG _____ B W NG _____	C 12/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE, ZIP CODE
CROFTON CONVALESCENT CENTER	**2131 DAVIDSONVILLE ROAD CROFTON, MD 21114**

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LABORATORY DIRECTOR'$ OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE TITLE tMI OATE

Any delic1ency 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 lo the patients _ (See instructions.) Exoepl for nursing homes. the findings stated above are disc/osable 90 days following the date of survey whether or not a plan or correctioo is provided For nursing homas. 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 participaUoo.

Office pf Health Care Oualitv

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215120	A. BUILDING: _____ B v.ING _____	C 12/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE, ZIP CODE
CROFTON CONVALESCENT CENTER	2131 DAVIDSONVILLE ROAD CROFTON, MD 21114

(X)IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	JO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPIETE DATE
S000	Initial comments On 12/18/18, a survey was conducted at this facility by the Office of Health Care Quality to investigate complaint #MD00134619. Activities induded the interview of the facility's business office personnel and an audit of the residents' personal funds records maintained by this facility. The complaint was unsubstantiated. This survey did not identify noncompliance with State requirements that were reviewed in relationship to the complaint.	S 000		

OHCQ
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (XS) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIERJCLIA IDENTIFICATON NUMBER	(X2) MULTIPLE CONSTRUCTDN	(X3J DATE SURVEY COMPLETED
	215120	A BUILDING _____ B WING _____	C 12/1812018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE ZIP CODE
CROFTON CONVALESCENT CENTER	**2131 DAVIDSONVILLE ROAD CROFTON, MD 21114**

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACHDEFICIENCYMUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRO VIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY	(XS) COMPLE TION DATE
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | ()(8J 0ATI!

Any deficiency statement ending with an asterisk (') denotes a deficiency which the institution *may* be excused from correcting providing 1t 1s determined that other safeguards provide sufficient protection to the patients. (See instructions.} Except ror nursing homes, the findings slated above **are** dtsclosable 90 days following the date of survey whether or not a plan of correction is provided For riursmg homes. the above findings arid 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 partic1patioo.

MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY
SPRING GROVE CENTER
BLAND BRYANT BUILDING
S:S WADEAVENUE
CAI'ONSVILLE, MARYLAND 21228

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21Jl DavlfbonvUJ<1 Road
Crofton, MI) 211 f-4

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Con1prcltensl\'c *cm,* facility - 180 Beds

Di.lo ls,ucd: December 31, 2016

This license has been gmnlcd to: Croflon Conv11tcsccnt Ccnlcr lnc.

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Octob4tr27,2016

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2131o.vtdsonvllle Road
Crohon, MD 21114

Ot!ar Mr. Gordon:

This tetttr Is. to acknowledge rectlpt an ap ieatlon toope,at• Crofton eonvarescent Center.

The et1do1ed Htctn:sC! wlU beIneffctet untllDecember 31. 2018, unteu re,,okad. tt ls vour autho,lty to m1lntaln*a* comprehensive corefacHltywithallcen1ied CilPiildW of 180 beds uner the prowislon of COMAA 10.07.02.

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The bed and room breakdown Is attadied.

Slncerely.

?f -M
Offkeof Health Cure Qu11llty

MH/Cjc

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Philip *I. Gotdon* S,.• Admlnlstratcr
Crofton Conva11!$Cctnt Center
P.ige,Two
Octabet 17, 2016

Roam and bed brnkdown:

CATEGOBY	LOCATION	mm
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	Triple Rooms.! 2u.215. *211.* 222. 223. 224	18bfds
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SECTION A - LONG TERM CARE PROVIDER APPLICATION

APPLICANT INFORMATION E-mail pgordon@croftoncrc.com Fax (410) 721-2749

Name of Facility Crofton Convalescent & Rehabilitation Center Telephone No (410) 721-1000

Location 2131 Davidsonville Road
(Street)

Crofton (City) Anne Arundel (County) 21114 (Zip)

OCT 20 2016

TYPE OF BUSINESS ORGANIZATION
[ ] Individual [ ] Partnership [X] Corporation [ ] Association [ ] Other: _____

TYPE OF CONTROL [X] Proprietary [ ] Voluntary Non-Profit: [ ] Church [ ] Other (Specify) _____
[ ] Government Unit: [ ] State [ ] City [ ] County

LEASING ARRANGEMENT (If an entity operates the business under a lease, the following section shall be completed):
Lessee Name(s) and Address(es) _____
Lessor Name(s) and Address(es) _____
Expiration Date of Lease _____

Applications on behalf of a corporation, association, government unit or agency shall be made by two officers of the corporation, association or governmental unit or agency and names and addresses of their board members shall be submitted.

Administrator Philip J. Gordon, Sr., N.H.A. Administrator License No: R0936

LONG TERM CARE FACILITY TYPE
[X] Nursing Home Comprehensive Care Facility
[ ] Hospital Extended Care Facility
Number of Beds 180
[X] Room & Bed breakdown attached Attachment #1

[ ] Does facility operate a special care unit?
[ ] YES: Type _____
Number of Beds _____
[ ] NO

The 2-year license fee of $ 7,000.00 (see fee rates below) is to be attached to the application. (Fee is not refundable). Make check or money order payable to "Maryland State Department of Health and Mental Hygiene"
Fee: 1 - 50 beds, $3,000 51-99 beds, $5,000 100+ beds, $7,000 Transitional care unit, $600

I/We Philip J. Gordon, Sr., N.H.A., Administrator
(Please Print)

certify that I am/We are 18 years of age or older and of reputable and responsible character do hereby apply for a license to maintain and operate a facility subject to the provisions of Health-General Article, Title 19, Subtitle 3, Annotated Code of Maryland, and to the regulations adopted there under by the Secretary of Health and Mental Hygiene.

1. Signature of Applicant _____ Title Administrator

2. Signature of Applicant _____ Title Secretary/Treasurer

Sworn and subscribed to before me this 25th day of September, 2016 a Notary Public for the State of Maryland.

My Commission expires September 6, 2019 Cynthia Colarusso
Notary Public

CYNTHIA COLARUSSO-IANNI
My Commission Expires
NOTARY PUBLIC
09-06-2019
ANNE ARUNDEL COUNTY, MD

SEND COMPLETED APPLICATION TO:

Office of Health Care Quality
Bland Bryant Building
Spring Grove Hospital Center
55 Wade Avenue
Catonsville MD 21228

FOR OFFICE USE ONLY

[ ] Initial Date: _____ Amt Pd: _____
[ ] Renewal Ck#: _____ Coord Name: _____
[ ] Change of Ownership Registration #: _____ License#: _____

DHMH 125A – Revised 3/16/2010

ROOM & **BED BREAKDOWN** IS AS FOLLOWS:

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	Duplex Rao : 201, 203--21 J. 219.225, 227-Z33	38 bed.-.
	T1lplc Roon: 2.13. 21s. 211. 222-224	18 bcd..4-
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	Duplex Room.c: 301	12 beds
	Triple Room. 303-318. 320. 322	54 beds
	Quad Roonm: 302	24 beds
	ToUII Third Floor	90 Beds
	OVERALL TOTAL	180 BEDS

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September 20. 2016

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L<mg Term Care Unit
Spring Grove Center - Bhmd Bryant Bulding
5S Wndc Avenue
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SECTION D- LONG TERM CARE PllOVIDER APPLICATION

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Principal Physician (signature)

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T (,phON Numr.tl'(l): (410) 121.1000

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SECTION B- LONG TERM CARE PROVJPER APPLICATION

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SECTION C- LONG TERM CARE PROVIDER ArPLICATION

DIRECTOR OFNURSING AOREF.MliNT

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MEOJCA'I. CARE PROGRAM• PROVIDER APPLICATION

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Requested Enrollment Begin Date

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4) PRACTICE INFORMATION

* Please refer to the instructions for appropriate codes.

* Type of Practice	*HMO Type Category
10	

5) SPECIALITY INFORMATION

* Please refer to the instructions for the appropriate codes.

6) SPECIALTY VERIFICATION

Please check the applicable statement and attach the required documentation. Pursuant to amendments to Physicians Services Regulations (COMAR 10.09.02), effective July 1, 1979, the Medical Assistance Program defines a Consultant-Specialist as a licensed physician who meets one of the following criteria:

☐ I have been declared board certified by a member of the American Board of Medical Specialists and currently retain that status. A photocopy of my specialty board certificate is attached.

☐ I have satisfactorily completed a residency program accredited by the Liaison Committee for Graduate Medical Education or by the appropriate residency review committee of the American Medical Association. Attached is a letter of verification from the chairman of the department where I completed my residency or where I am now working. This letter includes the name of the hospital where I completed my residency, length of my residency, by whom the program is accredited and the completion date of my residency.

☐ I have been declared board certified by a specialty board approved by the Advisory Board of Osteopathic Specialists and the Board of Trustees of the American Osteopathic Association. A photocopy of my specialty board certificate is attached.

☐ I have been declared board eligible by a specialty board approved by the Advisory Board of Osteopathic Specialists. Verification from my specialty that I am board eligible is attached.

☐ I have completed a residency program in a foreign country. My qualifications and training are acceptable for admission in the examination system of the appropriate American Specialty Board. A letter of my specialty board verifying this is attached.

If your application is for a group or professional association, each physician in the group or association who wishes to be considered a specialist must submit the required verification.

7) GROUP MEMBERSHIP INFORMATION

9) ALTERNATIVE ADDRESS INFORMATION

Pay to Address

Address		
City		Zip Code

Correspondence Address

Address		
City	State	Zip Code

Would you prefer to receive electronic correspondence, including remittance advices, in lieu of paper, when available? ☐ YES ☐ NO

10) OTHER PRACTICE LOCATION INFORMATION

Please enter other locations where you service Maryland Medicaid recipients. Include all group addresses you are currently practicing under.

		Zip code
	County Code	
	State	Zip Code
		License Number Expiration Date

SECTION D - MEDICAL CARE PROGRAM * PROVIDER APPLICATION

11) AUTHORIZATION

I, the practitioner, administrator or authorized professional representative of this group, hereby affirm that this information given by me is true and complete to the best of my knowledge and belief. I understand that if I or my group is salaried by a hospital or other institution for patient care, that I or my group will not bill the Maryland Medical Care Program for those services for which I or my group is salaried.

Date 9/20/2016

Signature of Practitioner, Administrator or Authorized Professional Responsible for the Quality of Patient Care

Philip J. Gordon, Sr., N.H.A., Administrator

Print or Type Name of Practitioner, Administrator or Authorized Professional Responsible for the Quality of Patient Care

Signature of Owner (in the case of a Pharmacy)

Please return completed application to:

Systems and Operations Administration
Provider Enrollment
P.O. Box 17030
Baltimore, MD 21203

SECTION D - PROVIDER APPLICATION * PRACTITIONER AND GROUP ADDENDUM

PRACTITIONER

If you are participating in a group practice, do you also provide care to Maryland Medicaid recipients in your private practice and wish to be reimbursed directly by the State? (Your personal tax identification number must appear on this application)

☐ YES ☐ NO

GROUP

If your group is affiliated with a health care institution or medical school, please enter the name and full address of the institution or school, your title and a brief explanation of your group's duties:

Name of Facility _____

Address _____

Title _____

Duties _____

Is your group salaried by the above institution? ☐ YES ☐ NO

If you are a M.D. or D.O. will you be dispensing pharmaceuticals other than samples (as a pharmacy)? ☐ YES ☐ NO

If you are an O.D., are you practicing optometry exclusively? ☐ YES ☐ NO or optometry as well as preparing and dispensing eyeglasses (as an optician)? ☐ YES ☐ NO

Is your group operating a Local Health Department Clinic? ☐ YES ☐ NO

Is your group operating a Freestanding Clinic ☐ YES ☐ NO

NOTE: All practitioners in a group must be enrolled as Medical Care Program providers.

LABORATORY INFORMATION

Completion of this section is required by individual practitioners and groups. Reimbursement for medical laboratory services you provide to eligible recipients is dependent on answering the following questions and supplying codes of CLIA Certificate and, when required, Maryland Laboratory Permits or Letters of Exception. Practitioner providers cannot be reimbursed for services referred to medical laboratories or other practices. Those laboratories or practices must bill.

Do you provide medical laboratory services for your own patients? ☐ YES ☐ NO

Do you provide medical laboratory services for other than your own patients? ☐ YES ☐ NO

Do you receive specimens that are obtained from other sites located in Maryland? ☐ YES ☐ NO

All Maryland practitioners are required to have a Maryland Laboratory Permit or Letter of Exception Number (§Health General Article 17-202 and 17-205, Annotated Code of Maryland) and CLIA Certificate Number (Clinical Laboratory Improvement of 1988 Public Law 100-578) to perform laboratory services. Out-of-state providers are only required to provide their CLIA Certificate Number, if they do not receive specimens that originate in Maryland.

DIALYSIS FACILITIES

Medicare Provide Number _____

Attach a copy of letter with assigned Medicare Provider Number.

Attach a copy of the letter(s) from your intermediary showing all current composite rates.

Note: You will be paid ONLY for the rate(s) appearing in this/these letters(s) in addition to those services provided, but not included in the composite rate.

PORTABLE X-RAY AND OTHER DIAGNOSTIC SERVICES MUST SUPPLY THE FOLLOWING:

Maryland Medical Test Unit Permit No. _____

Do you intend to bill for portability? ☐ YES ☐ NO

Note: All portable x-ray and other diagnostic service providers located within Maryland or serving patients located within Maryland MUST have a Maryland Test Unit Permit. The only out-of-state portable x-ray and other diagnostic services providers that do not have to have a Maryland Medical Test Unit Permit are those that serve Maryland Medicaid recipients in the State in which the provider is located and they must provide a Medicare number.

LABORATORY INFORMATION

Completion of this section is required. Reimbursement for medical laboratory services you provide to eligible recipients is dependent on answering the following questions and supplying copies of CLIA Certificate and, when required, Maryland Laboratory Permits or Letters of Permit Exception. Practitioner providers cannot be reimbursed for services referred to medical laboratories or other practices. Those laboratories or practices must bill.

Do you provide medical laboratory services for your own patients? ☒ YES ☐ NO

Do you provide medical laboratory services for other than your own patients? ☐ YES ☒ NO

Do you receive specimens that are obtained from other sites located in Maryland? ☐ YES ☒ NO

All Maryland practitioners are required to have a Maryland Laboratory Permit or Letter of Exception Number (§Health General Article 17-202 and 17-205, Annotated Code of Maryland) and CLIA Certificate Number (Clinical Laboratory Improvement of 1988 Public Law 100-578) to perform laboratory services. Out-of-state providers are only required to provide their CLIA Certificate Number, if they do not receive specimens that originate in Maryland.

PLEASE COMPLETE FORM DHMH 4126-G, PROVIDER OWNERSHIP AND CONTROL DISCLOSURE FORM, AND SUBMIT WITH PROVIDER APPLICATION.

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SECTION D

PROVIDER OWNERSHIP AND CONTROL DISCLOSURE FORM

I hereby affirm that this information is true and complete to the best of my knowledge and belief, and that the requested information will be updated as changes occur. I further certify that upon specific request by the Secretary of the Department of Health and Human Services or the Maryland Department of Health and mental Hygiene, full and complete information will be supplied within 35 days of the date of the request, concerning:

A. the ownership of any subcontractor with which the title XIX Provider has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000.00 and

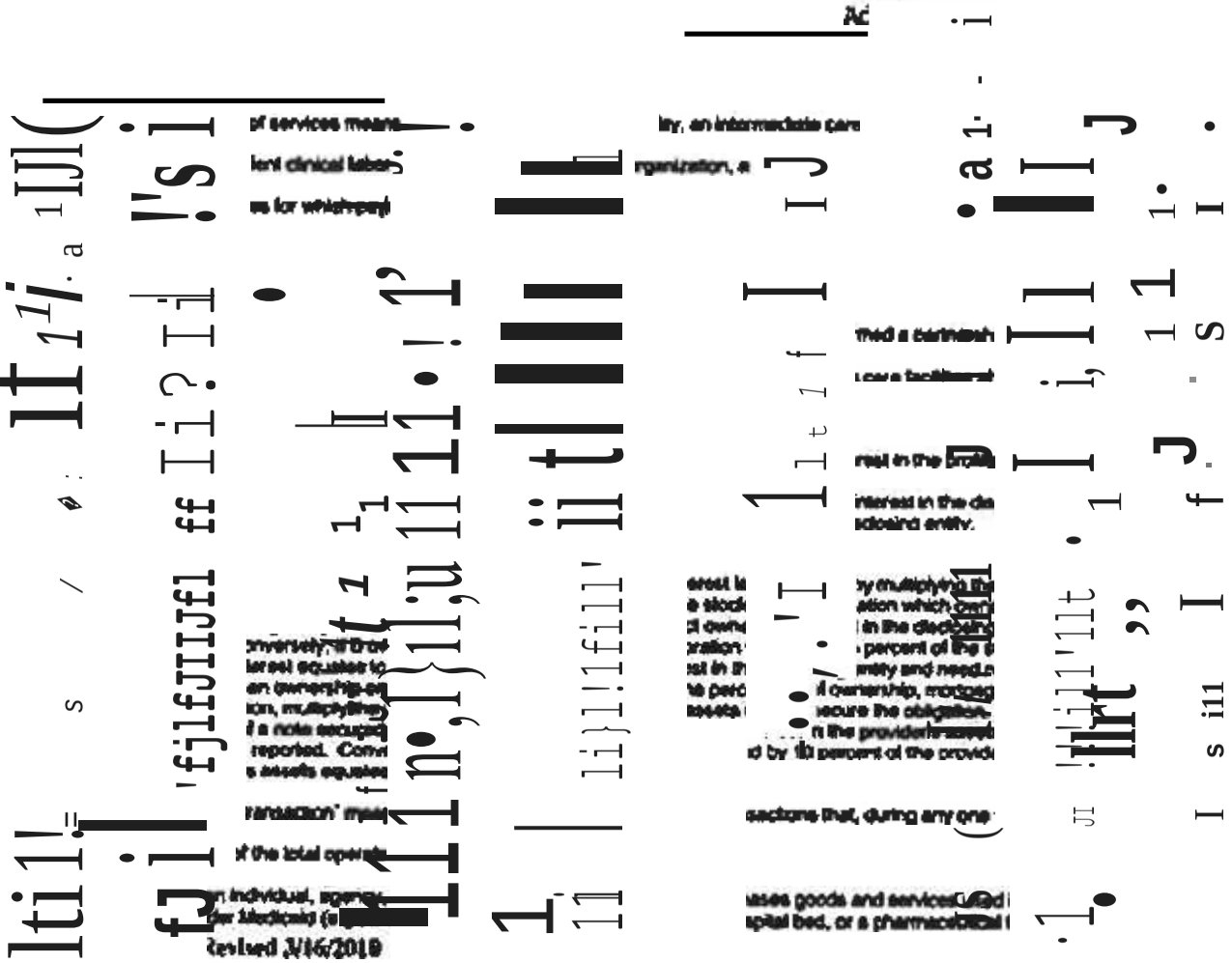
B. any significant business transactions*, occurring during the 5-year period ending on the date of such request, between the Provider and any wholly-owned supplier** or any subcontractor,

C. the identity of any management company that will operate or contract with the applicant to operate the facility.

D. the ownership of equipment utilized for direct patient care.

Philip J. Gordon, Sr., N.H.A.

AUTHORIZED SIGNATURE



Revised 3/16/2010

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SECTION 0- CERTIFICATE OF COMPLIANCE APPLICATION

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SECTION G – CERTIFICATE OF COMPLIANCE APPLICATION

CERTIFICATE OF COMPLIANCE

Before a governmental unit may issue a license or permit to a business for the purpose of engaging in an activity in which the business might employ a covered employee, the business shall submit to the governmental unit:

(1) a certificate of compliance with this title; or
(2) the number of a workers' compensation insurance policy or binder.

If a business is not covered by a workers' compensation insurance policy, an application to secure a Certificate of Compliance shall be submitted to the Workers' Compensation Commission pursuant to Labor & Employment Article §9-105. The sole purpose of a Certificate of Compliance is to identify those businesses which are not required to carry workers' compensation insurance coverage and to enable that business to apply for and obtain a license or permit from a government agency that requires proof of workers' compensation insurance coverage. A Certificate of Compliance is **not** workers' compensation insurance and is not binding on the Workers' Compensation Commission under any circumstances.

NOTE: Maryland Annotated Code LE §9-201 requires a business with one or more employees to carry workers' compensation insurance.

Eligibility: A business may secure a Certificate of Compliance in the name of the business, only if:

(a) the business is a sole proprietor with no employees;

(b) the business is a partnership with no employees other than the individual partners;

(c-Q) the business is a Farm Corporation, a Maryland Close Corporation, a Professional Corporation or a Limited Liability Company with no employees other than corporate officers or limited liability company members who have elected, under §9-206, to be excluded from workers' compensation coverage;

(g) the business is an employer of only "casual employees" as provided under LE §9-203 and defined in Maryland Law; or

(h) the business is an owner operator of a Class F (Tractor) vehicle who meets the requirements of exclusion as defined under LE §9-218.

Mail Application to: The Workers' Compensation Commission
Attention: Certificate of Compliance Officer
10 East Baltimore Street • Baltimore, Maryland 21202-1641

Facsimile Applications Will Not Be Accepted. Do not photocopy or electronically reproduce.

ON FOR CERTIFICATE OF COMPLIANCE

a. _____
Name of Business (If trading as set[leave blank)

b. _____
Name of Owner(s) If a partnership, print each partner's name (attach separate sheet if necessary)

c. _____ _____ _____ _____
Business Address (P. O. Box Not Acceptable) City State Zip Code

d. _____ _____ _____ _____
Mailing Address City State Zip Code

e. (_____) _____ _____
Phone Number (Prefer Number Not Acceptable) FEIN or Social Security Number(s)

f. The above named business would qualify for a Certificate of Compliance for the following reason: (Check the appropriate box and do not modify or qualify the stated reasons in any way.)

a. ☐ Sole Proprietor: The business is a sole proprietorship with no employees.
b. ☐ Partnership: The business is a partnership with no employees other than the individual partners.
c. ☐ A Maryland Close Corporation (attach Application Form C-1427): The business is a Maryland Close Corporation with no employees other than corporate officers.
d. ☐ Farm Corporation (attach Business Form C-1428): The business is a farm corporation with no employees other than corporate officers.
e. ☐ Professional Corporation (attach Application Form C-1429) The business is a professional corporation with no employees other than corporate officers.
f. ☐ Limited Liability (attach Application Form C-1430) The business is a limited liability company with no employees other than limited liability company members.
g. ☐ Casual Employer: The business only employs casual workers as provided in LE §9-205 and defined under Maryland Laws.
h. ☐ Owner/Operator of Class F Vehicle: The business is that of an owner operator of a Class F (Transit) vehicle and meets the requirements of exclusion as defined under LE §9-218.

I AFFIRM UNDER THE PENALTIES OF PERJURY THAT THE FOREGOING INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.

g. _____ _____
Signature(s) If a partnership, all partners must sign (Use separate sheet if necessary) Date

After careful review of this application and based solely on the information contained in or attached to this application, the application is ☐ APPROVED ☐ DISAPPROVED.

_____ _____
Authorized Signature Date

An applicant who receives notice of disapproval may (1) reapply for a certificate of compliance or (2) appeal the rejection in accordance with §§ 10-222 and 10-223 of the State Government Article.

Form AT2 (Rev. 12/1/98)

WORKERS' COMPENSATION COMMISSION
10 East Baltimore Street
Baltimore, Maryland 21202-1641
TEL: (410) 864-5100 OR (1-800) 492-0479
TTY USERS CALL VIA MARYLAND RELAY

Date Stamp – WCC Use Only

EXCLUSION FORM

Pursuant to the provisions of Labor & Employment Article § 9-206 of the Annotated Code of Maryland, officers or members of a Farm Corporation, Close Corporation, Professional Corporation, or Limited Liability Company are covered employees if the officer or member provides a service for monetary compensation. Such officers or members who satisfy the criteria of Labor & Employment Article § 9-206(b) may elect to become excluded from coverage by filing this Exclusion Form with the Commission.

To exercise this option, any officer or member from the aforementioned types of organizations wishing to be excluded must sign this document. **NOTE:** By signing this Exclusion Form below, each officer or member affirms under the penalties of perjury that the information contained in this form is true and correct as to that officer or member, to the best of the officer's or member's knowledge, information, and belief.

DATE: _____ DATE COMPANY NOTIFIED INSURANCE COMPANY: _____

NAME OF CORPORATION'S INSURANCE COMPANY: _____

NAME OF COMPANY: _____

TYPE OF COMPANY: (Circle One) Farm Corporation, Close Corporation, Professional Corporation, Limited Liability Company

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

IMPORTANT: Submit original form to the Workers' Compensation Commission, a copy to the insurer of the corporation, and keep a copy for your files.

SECTION I: ADVERSE ACTIONS/CONVJt.110NS

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2131 DAVIDSONVJLLE ROAD
CROFl'ON, MD 21114

Dlrcccor; Dr RAKESH ARORA
Owner. MAX C. FRANK, M, D., l\lARTIN 8, LF.SSANS. ESQ.

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RAKESH AR.ORA
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CROFTON. MD 21114
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Attachment #4

CENTERS FOR MEDICARE & MEDICAID SERVICES
CLINICAL LABORATORY IMPROVEMENT AMENDMENTS
CERTIFICATE OF WAIVER

LABORATORY NAME AND ADDRESS
CROFTON CONVALESCENT CENTER
2131 DAVIDSONVILLE ROAD
CROFTON, MD 21114-1632

CLIA ID NUMBER
21D0880231

EFFECTIVE DATE
12/08/2015

LABORATORY DIRECTOR
RAKESH ARORA MD

EXPIRATION DATE
12/07/2017

Pursuant to Section 353 of the Public Health Service Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown herein (and other approved locations) may accept human specimens for the purpose of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

Karen W. Dyer, Acting Director
Division of Laboratory Services
Survey and Certification Group
Center for Clinical Standards and Quality

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- If this is a Certificate of Registration, it represents only the enrollment of the laboratory in the CLIA program and does not indicate a Federal certification of compliance with other CLIA requirements. The laboratory is permitted to begin testing upon receipt of this certificate, but is not determined to be in compliance until a survey is successfully completed.
- If this is a Certificate for Provider-Performed Microscopy Procedures, it certifies the laboratory to perform only those laboratory procedures that have been specified as provider-performed microscopy procedures and, if applicable, examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.
- If this is a Certificate of Waiver, it certifies the laboratory to perform only examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.GOV/CLIA OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER. PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.

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(Tags: Coronavirus attorney, nursing home lawyer, nursing home attorney, medication error, pressure sores, bed sores, sepsis, wrongful death, wounds, falls, attorney handling medication errors, nursing home abuse attorney, assisted living attorney, assisted living accidents, dehydration, malnutrition claim, Maryland elder abuse attorney, nursing home injury, skilled rehab injury, skilled rehab attorney, drugs, pharmaceutical drugs, antipsychotic drugs, negligence attorney, nursing home abuse attorney, adult protective service lawyer, overdose, legal liability for overdose, nursing home abuse lawyer, nursing home chains, statistics on nursing home abuse, wrongful death case or claim, Maryland Nursing abuse attorney, Maryland nursing home attorney, pressure sores, Crofton Convalescent Center, Crofton malpractice attorney, Ann Arundel County malpractice attorney)