##### **FOIA Data Base** - The Law Office of Jeffrey 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](mailto:jdowney@jeffdowney.com)

Malta House - North 4916 LaSalle Road

Hyattsville, MD 20782

Facility Characteristics

* Assisted Living Facility with 15 Beds
* Date Facility First Opened:
* [http://www.victoryhousing.org](http://www.victoryhousing.org/)
* Non- Profit Corporation managed by Victory Housing, Inc.
* Director – Elizabeth Orchard 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 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’s Office of Health Care Quality inspect assisted living facilities, including Malta House North – in Hyattsville, MD. Periodically, they do inspections as complaint surveys which should be for public record. You can write to the following address:

Maryland Department of Health Office of Health Care Quality 7120 Samuel Morse Drive Second Floor

Columbia, MD 21046-3422

You may also email [AL.Help@maryland.gov](mailto:AL.Help@maryland.gov) or call (410) 402-8015

Having already researched Malta House - North in Hyattsville, 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.

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.

**Disclaimer:** Information is built using data sources published by Centers for Medicare & Medicaid Services (CMS) under Freedom of Information Act (FOIA). The information disclosed on the NPI Registry are FOIA-disclosable and are required to be disclosed under the FOIA and the FOIA amendments to the FOIA. There is no way to 'opt out' or 'suppress' the NPPES record data for health care providers with active NPls. Some documents may not be accurately copied or some results may have changed upon appeal, which may not be noted here.

Office of Health Care Quality

PRINTED: 09/10/2019 FORM APPROVED

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **16AL397** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING: 2. WING | | (X3) DATE SURVEY COMPLETED  **04/23/2018** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **4916 LASALLE ROAD**  **MALTA HOUSE - NORTH**  **HYATTSVILLE, MD 20782** | | | | | | |
| (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 |
| E 000 | Initial Comments  On 04/23 and 25/2018, a re-licensure survey was conducted, survey included: interviews with Assisted Living Manager (ALM) , tour of the facility, review of staff, resident, and administrative records.  The facility was determined to be in compliance with COMAR 10.07.14, Assisted Living Program regulations.  Census at the time of the survey was fifteen (15) residents. | | E 000 |  | |  |

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

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| STATEMENT OF DEFICIENCIES  !ANDPLAN OF CORRECTION | | (X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATIONNUMBER  16AL397 | | | ( X2) M UL TIPL E CONSTRUCTI R **ECE** I **V**  A BUILDIN\_G \_ \_ \_ \_ \_ \_ \_  B WING OCT O 5 20 | | **E** e t i T V; Y  5 09 /02/2015 | |
| NAME OF PROVIDER OR SUPPLIER  MALTA HOUSE • NORTH | | | STREETADDRESS, CITY, STATE, ZIP CODE  **4916 LASALLE ROAD** Office of  **HYATTSVILLE, MO 20782** Health Care Quality | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCYMUST 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 |
| Eooo  E4810 | Initial Comments  On September, 2, 2015, an inspection of care survey was conducted by a representative of the Office of Health Care Quality to determine whether the immediate health and safety needs of the residents were being met and to determine compliance with COMAR regulations 10.07.14, Assisted Living Program Regulations.  Survey activities included observations, an environmental tour, review of three (3) randomly selected resident records; review of selected administrative policies and procedures for the facility; review of selected training records for the assisted living manager (ALM), the alternate assisted living manager (AALM), the delegating registered nurse/case manager (ORN/CM), and three (3) staff, and interview of two (2) residents and the AALM, the ORN/CM and one (1) staff. The census at the time of the survey was fifteen (15) residents.  Based on survey findings, the facility was found to be in violation of the regulations governing assisted living facilities, COMAR 10.07.14.  .46 C4 .46 Emergency Preparedness   1. The brief medical fact sheet for each resident described in §C(3) of this regulation shall be:    1. Updated upon the occurrence of change in any of the required information;    2. Reviewed at least monthly; and    3. Maintainedin a central location readily accessible and available to accompany residents In case of an emergency evacuation.   This Requirement is not met as evidenced by. Based on record review and interview, the facility failed to update the residents' medical fact sheet | | | E 000  E4810 | | The Alternate Ass is ted Living Manager reviewedall medical fact sheets.  The Alternate Assisted Living Manager will review the medical fact sheet on a  monthly basis and will record the completed review on a new form printed on the back of the medical fact sheet.  Beginning immediate ly, the Assisted Living Manager will implement a new process of reviewingthe medical fact sheets monthly and will conduct monthly checks of the reviews until April 2016. Any issues with  be refen-ed to the Quality Assurance re view. | | 09/23/15 |

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| STATEMENT OF DEFICIE N CIES IANO PLAN OF CORRECTION | | (XI ) PROVlOER/SUPPLIER/CLIA IDENTIFICATION NUMBER  16AL397 | | | (X2) MULTIPLECONSTRUCTION   1. BUI L DIN G\_ \_ \_ \_ \_ \_ \_ \_ 2. IIVING | | (X3) DATE SURVEY COMPLETED  09/02/2015 | |
| NAME OF PROVIDER OR SUPPLIER  **MALTA** HOUSE · NORTH | | | STREET ADDRESS. CITY, STATE, ZIP CODE  **4916 LASALLE ROAD**  **HYATTSVILLE, MD 20782** | | | | | |
| (X4) 10 PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORYOR LSC IDENTIFYING INFORMATION) | | | 10  PREF I X TAG | | PROVIDER'S P LAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY) | | **(XS)**  COM PLE TE DATE |
| E4810 | Continued From Page 1  monthly as required by the Department.  Findings included: | | | E4810  E4910 | |  | |  |
| At the time of the survey, the Emergency Disaster Plan the AALM provided for review by the surveyor included for each resident a packet containing 1)anemergency data sheet, 2)a physician's medication order form, and 3)a medication administration record. The AALM related this packet was utilized rather than a specific medical fact sheet for each resident. The Delegating Registered Nurse/Case Manager (ORN/CM) related that the physician's medication order form was changed each month in each resident's packet; however, the emergency data sheet was updated/reviewedonly when there was a change in condition, diagnosis or physician's orders. Thus, although the emergency data sheet provided the information required on a medical fact sheet, there was no documentation of any monthly update/review for the accuracy of the information on the emergency fact sheet. including information on the resident's representative, insurance informationor mobility.  Therefore, the facility failed to ensure that there was documentation of a monthly review of the form the facility was utilizing as a medical fact sheet for each resident as part of the facility's emergency disaster plan.  E4910 .46 E3 .46 Emergency Preparedness | | | |
|  | (3) Semiannual Disaster Drill.  (a) The assisted living program shall conduct a semiannual emergency and disaster drill on all shifts during which it practices evacuating residents or sheltering in-place so that each is | | |

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OFFICE OF HEALTH CARE QUALITY

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| STATEMENT OF DEF ICIENCIE S D PLANOF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER  16AL397 | | | (X2) MULTIPLE CONSTRUCTION  A BUILDIN\_G \_ \_ \_ \_ \_ \_ \_  B. \MNG | | (X3) DATE SURVEY COMPLETED  09/02/2015 | |
| NAME OF PROVIDER OR SUPPLIER  MALTA HOUSE · NORTH | | | STREET ADDRESS. CITY, STATE, ZIP CODE  **4916 LASALLE ROAD**  **HYATTSVILLE, MD 20782** | | | | | |
| (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 (EACHCORRECTIVE ACTION SHOULD BE  CROSS-REFERENCEDTO THE APPROPRIATE  DEFICIENCY) | | **(XS)** COMPLETE DATE |
| E4910 | Continued From Page 2  practiced at least one time a year.   1. The drills may be conducted via a table-top exercjse if the program can demonstrate that moving residents will be harmful to the residents. 2. Documentation. The assisted living program shall: 3. Document completion of each disaster drill or training session, 4. Have all staff who participated in the drill or training sign the document; 5. Document any opportunities for improvement as identified as a result of the drill; and 6. Keep the documentaiton on file for a minimum of 2 years.   This Requirement is not met as evidenced by: | | | E4910 | |  | |  |
|  | Based on record review and interview, the facility failed to ensure that there was documentation that the facility conducted semiannual disaster drills on each shift.  Findings included.  At the time of the survey, the AALM related that the facility's shifts were 7 AM until 3 PM; 3 PM until 11 PM; and 11 PM until 7 AM. Documentation available demonstrated that a disaster drill had taken place on July 9, 2015 on the 7 AM until 3 PM shift and a second disaster drill had taken place on July 29, 2015 *for* all three (3) shifts; however, no documentaiton was available to indicatethat any disaster drills had taken place in the facility between January and June of 2015.  Therefore, the facility failed to ensure that there was documentation that disaster drills were conducted at least semiannually on all shifts. | | |
| A emergency and disaster drill was conducted I 0 /3 1/ I 5 on December 31s t, 2014 and July 291h, 2 0 IS.  A se mi-annual emergency and disaster drill will be conducted during which all residents will evac uated or sheltered in place. The drill be conducted and documented on all three shifts (7.00 am - 3.00 pm, 2.30 pm - I 1.00 pm and 11.00 pm - 7.00 am) by the Assisted Living Manager. All staff who will participate in the drill will s ign the documentation.  The Assisted Living Manager will document any opportunities for im provement.  Starting imme diately, the Assisted Living Manager will be responsible for conducting the required semi-annual emergency and disaster drills according to Comar .46 E3 .46 | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **16AL397** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING: 2. WING | | (X3) DATE SURVEY COMPLETED  C  **02/06/2015** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **4916 LASALLE ROAD**  **MALTA HOUSE - NORTH**  **HYATTSVILLE, MD 20782** | | | | | | |
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| E 000 | Initial Comments  On 2/6/2015, an unannounced visit was made to the above named facility to conduct a complaint investigation. Survey activities included interviews of the facility Director and a resident and a review of a resident's record.  Based on survey findings, in relation only to complaint # MD 00085426, the facility was found to comply with the regulations governing assisted living facilities, COMAR 10.07.14.  The facility's census at the time of the survey was thirty-one (31) residents. | | E 000 |  | |  |

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **16AL397** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING: 2. WING | | (X3) DATE SURVEY COMPLETED  C  **01/27/2015** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **4916 LASALLE ROAD**  **MALTA HOUSE - NORTH**  **HYATTSVILLE, MD 20782** | | | | | | |
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| E 000 | Initial Comments  On 1/23/15, an unannounced complaint investigation was conducted by a representative from the Office of Health Care Quality at the above named facility in relation to Complaint # MD00087791 for the purpose of determining the facility's compliance with COMAR 10.07.14, Assisted Living Regulations. Survey activities included resident record reviews, incident reports reviews, review of facility records including activity rosters, interview of staff and residents, and observation of the environment. Based on survey findings, in relation only to complaint # MD00087791 referral allegations, refer to complaint # MD00087362.  The facility's census at the time of the survey was fifteen (15) residents.  Acronyms which may appear in this report are defined as follows:  ALM: Assisted Living Manager  AALM: Alternate Assisted Living Manager CDS: Controlled Dangerous Substance DN: Delegating Nurse  FA: Manager's Functional Assessment HCPPA: Healthcare Practitioner's Physical Assessment  MAR: Medication Administration Record RAT: Resident Assessment Tool  SP: Service Plan | | E 000 |  | |  |

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **16AL397** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING: 2. WING | | (X3) DATE SURVEY COMPLETED  C  **01/27/2015** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **4916 LASALLE ROAD**  **MALTA HOUSE - NORTH**  **HYATTSVILLE, MD 20782** | | | | | | |
| (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 |
| E 000  E3340 | Initial Comments  On 1/23/15, an unannounced complaint investigation was conducted by a representative from the Office of Health Care Quality at the above named facility in relation to Complaints # MD 00087362, MD 00087791, and MD 00087207  for the purpose of determining the facility's compliance with OMAR 10.07.14, Assisted Living Regulations. Survey activities included resident record reviews, incident reports reviews, review of facility records including activity rosters, interview of staff and residents, and observation of the environment. Based on survey findings, in relation only to complaints #MD 00087362, MD 00087791, and MD 00087207 referral allegations, the following deficiencies were identified on the date of the investigation.  The facility's census at the time of the survey was fifteen (15) residents.  Acronyms which may appear in this report are defined as follows:  ALM: Assisted Living Manager  AALM: Alternate Assisted Living Manager CDS: Controlled Dangerous Substance DN: Delegating Nurse  ALMA: Assisted Living Manager's Assessment HCPPA: Health Care Practitioner's Physical Assessment  MAR: Medication Administration Record RAT: Resident Assessment Tool  SP: Service Plan  .26 B3 .26 Service Plan  (3) When the delegating nurse determines in the nurse's clinical judgment that the resident does not require a full assessment within 48 hours, the delegating nurse shall: | | E 000  E3340 |  | |  |

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **16AL397** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING: 2. WING | | (X3) DATE SURVEY COMPLETED  C  **01/27/2015** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **4916 LASALLE ROAD**  **MALTA HOUSE - NORTH**  **HYATTSVILLE, MD 20782** | | | | | | |
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| E3340  E3420 | Continued From page 1   1. Document the determination and the reasons for the determination in the resident's record; and 2. Ensure that a full assessment of the resident is conducted within 7 calendar days.   This REQUIREMENT is not met as evidenced by:  Based on review of resident's record and DN/CM interview, the facility failed to provide a detailed, individualized service plan to ensure resident needs, as based on assessment, are met.  Findings include:  On 2/6/15 resident #2's service plan was not specific to meet needs. The ALM stated several things that are being done to meet needs; however they are not stated in the service plan.  .27 D .27 Resident Record or Log  D. Resident Care Notes.  (1) Appropriate staff shall write care notes for each resident:   1. On admission and at least weekly; 2. With any significant changes in the resident's condition, including when incidents occur and any follow-up action is taken; 3. When the resident is transferred from the facility to another skilled facility; 4. On return from medical appointments and when seen in home by any health care provider; 5. On return from nonroutine leaves of absence; and 6. When the resident is discharged permanently from the facility, including the location and manner of discharge.   (2) Staff shall write care notes that are | | E3340  E3420 |  | |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **16AL397** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING: 2. WING | | (X3) DATE SURVEY COMPLETED  C  **01/27/2015** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **4916 LASALLE ROAD**  **MALTA HOUSE - NORTH**  **HYATTSVILLE, MD 20782** | | | | | | |
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| E3420  E3790 | Continued From page 2  individualized, legible, chronological, and signed by the writer.  This REQUIREMENT is not met as evidenced by:  Based on review of resident's record and interview with the ALM and DN, the facility did not ensure each resident's care notes reflected significant changes in resident's condition including when incidents occur.  Findings include:  Resident #1 had an incident that occurred on 10/11/14 about 8 am documented on the incident report. The care notes dated 10/6/14 -10/12/14 says no visits, no changes.  The nurse practitioner visited resident#1 on 10/16/14 regarding the fall. The care notes dated 10/13/14-10/19/14 states no changes, no falls.  .31 C .31 Incident Reports  C. All incident reports shall include:   1. Time, date, place, and individuals present; 2. Complete description of the incident; 3. Response of the staff at the time; and 4. Notification, including notification to the: 5. Resident, or if appropriate the resident's representative; 6. Resident's physician, if appropriate; 7. Program's delegating nurse; 8. Licensing or law enforcement authorities, when appropriate; and 9. Follow-up activities, including investigation of the occurrence and steps to prevent its reoccurrence. | | E3420  E3790 |  | |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **16AL397** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING: 2. WING | | (X3) DATE SURVEY COMPLETED  C  **01/27/2015** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **4916 LASALLE ROAD**  **MALTA HOUSE - NORTH**  **HYATTSVILLE, MD 20782** | | | | | | |
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| E3790 | Continued From page 3  This REQUIREMENT is not met as evidenced by:  Based on review of administrative record, the facility did not ensure the incident report included measures to prevent reoccurrence of incident.  Findings include:  There was no documented evidence that preventive measures were put in place on the incident report dated 10/11/14 to prevent a reoccurrence. | | E3790 |  | |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **16AL397** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING: 2. WING | | (X3) DATE SURVEY COMPLETED  C  **01/23/2015** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **4916 LASALLE ROAD**  **MALTA HOUSE - NORTH**  **HYATTSVILLE, MD 20782** | | | | | | |
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| E 000 | Initial Comments  On 1/23/15, an unannounced complaint investigation was conducted by a representative from the Office of Health Care Quality at the above named facility in relation to Complaint # MD00087365 for the purpose of determining the facility's compliance with COMAR 10.07.14, Assisted Living Regulations. Survey activities included resident record reviews, incident reports reviews, review of facility records including activity rosters, interview of staff and residents, and observation of the environment. Based on survey findings, in relation only to complaint # MD00087365 referral allegations, refer to complaint # MD00087362.  The facility's census at the time of the survey was fifteen (15) residents.  Acronyms which may appear in this report are defined as follows:  ALM: Assisted Living Manager  AALM: Alternate Assisted Living Manager CDS: Controlled Dangerous Substance DN: Delegating Nurse  FA: Manager's Functional Assessment HCPPA: Healthcare Practitioner's Physical Assessment  MAR: Medication Administration Record RAT: Resident Assessment Tool  SP: Service Plan | | E 000 |  | |  |

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

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### STATE OF MARYLAND DEPARTMENT OF HEALTH



**OFFICE OF HEALTH CARE QUALITY**

SPRING GROVE CENTER BLAND BRYANtBUILDIN'G 55 WADE AVENUE

CATONSVILLE, MARYLAND 21228

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Li ce nse No. l6al397-J

Issued to: Malta I-louse, Inc.

Malta Ho use - North 4916 Lasalle Road

Hyattsville, MD 20782-3302

J ype of Facility: Assisted Living

Level of Care : 2 ,.

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.Numberof Beds: 15

Date l suep: July 1, 2018 Non-Expiring

Author;it to operate int his State is granted to theabQve·entiry pursuant to TI1e Heahh-Gencral Article, Title 19§

180I, et. seq., Annotated Codeof Marylan,d, including all appli le rule·s and regula tions promulgated there undc This document is not transferable.

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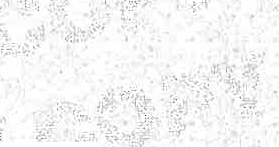
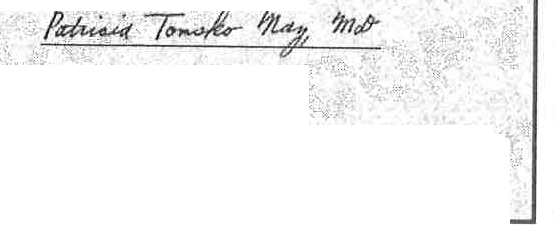
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Executive Director

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*Falsification of a license shall s11b ject th e perpetrator ro criminal p?osecution and the imposition of civilf,nei.* .-' ."'

: - **STATEOFMARYLAND**

**- DEPARTMENT OF HEALTH MENTAL HYGIENE OFFICE QF HEALTH CARE QUALITY**

SPRING GROVE CENTER ., BLAND B Y ANT BUILDING

55 WADE'AVENUE ,

CATONSViLLE, MARYLAND 21228

- ' '

Li ense No. **16AL397-J**

Isst'ied to: Malta H. o use, Inc: ,\_·

T / A Malta House - North

4 16 Lasa lle Road Hyattsville, MD 2078 3302

Type of Facility or Coo1mq!'lityPrqgram:

**Assist Living**

N umbe r of Beds:.

**15** ..



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* **TW O YEAR LICENSE**

Datet ss ued: November 7, 20 l7

Expiration Date:

November 6, 2019

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**Renewal License** - \_ReplacesLicense #16 AL397-I

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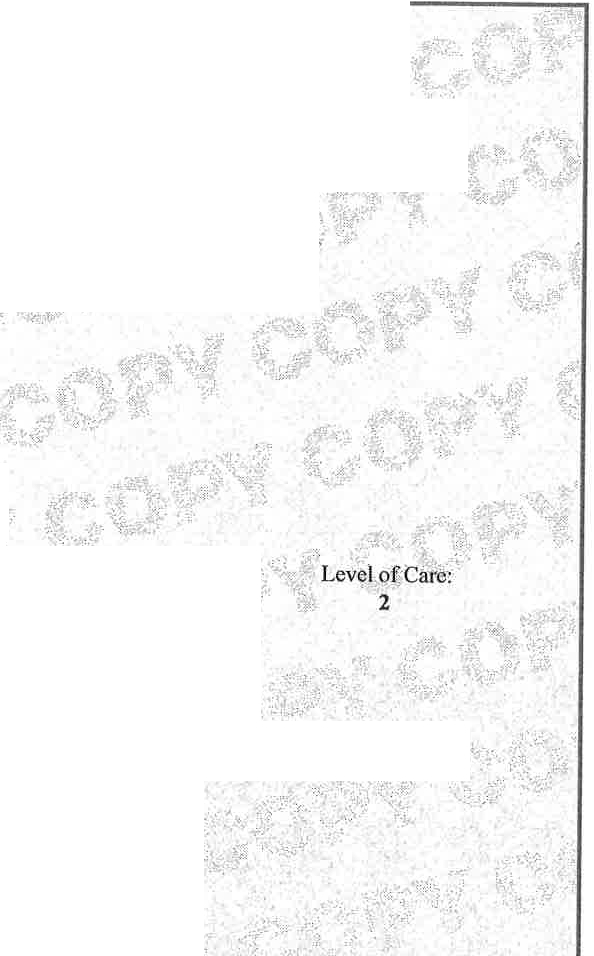
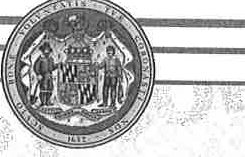
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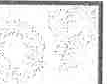
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### ,S TATEOF MARYL\_A,ND



**DEPARTMENT OF HEALTH AND IyIENTAL HYGIENE OFFICE OFHEALTll CARE QUALITY**

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Li ce nse No. **l6AL397 -I**

SPRING GROVE CENTER BLAND BRYANT BUILDING *55* WADE AVENUE

CATONSVILLE-,MARYLAND 21228

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Issued to: Malta House, lnc.

T/A Malta House - Nort h

4 )'16 LasaUe Ro d

Hya tts ville, MD 20782-3302

Type of Facility or Co mmuni ty Program:

, , **sisted Living**

Number of Beds:

, **15**·

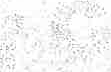
Level of Care:

2

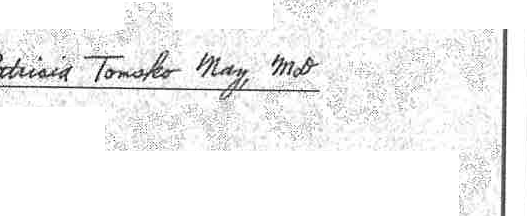
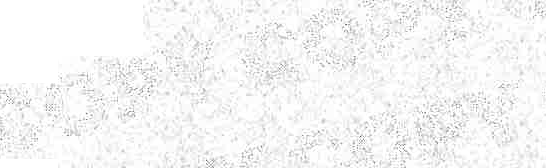
Date Issued: November 8, 2015

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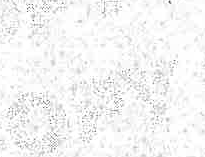
November 7, 2017



**Renewal Litense** - Replaces License #16AL397-H

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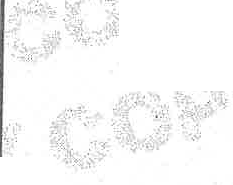
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*Falsification of a license shall subjectthe perpetrator to criminal prosecution and the imposition of civi( fines:*

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**STATE OF MARYLAND DEPARTMENT OF HEALT, HAND MENTAL HYGIENE**



**OFFICE O**. **F HE**•**A**. **LTH CARE QUALITY**

SPRING GROVE CENTER

*'I* BLAND. BRYANT BUILDlNG "•

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55Wl}.DEAVENUE

CATONS¥ILL£, MARYIAND 21228

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Li cense No. **16AL397-H**

Issued to: Malta House, Inc.

T/A Malta House:.. North 4916 alle Road

 Hyattsvi.lle, MD 2078 3 .04·•:

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Type of Facility or Coriimunity Program:

**Assisted Living**·

Number of Bed-s: *.:*

**15**

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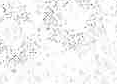
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November 8, 2013

**TWO YEAR LICENSE**

, Expirati 11 Date; · November 7, 2015

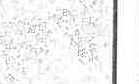
**R enewa l License**- RepJaces Lice nse #16AL397-G



..Authority to'.operafe in this State is granted to the above entity pt.lrsuanlto Tnc Health- ! cml Article, Title 19 § 18,0I .et

seq., Annolateii Code of Maryland, including all npplicablerul and regulations promulgated there under. 'fhidocu ent is

001 transferable. , • fr,•.· t,: ' ·< '

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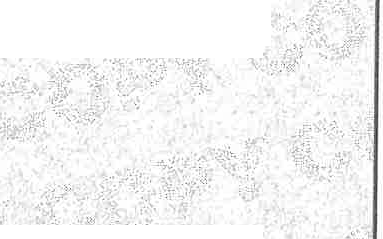
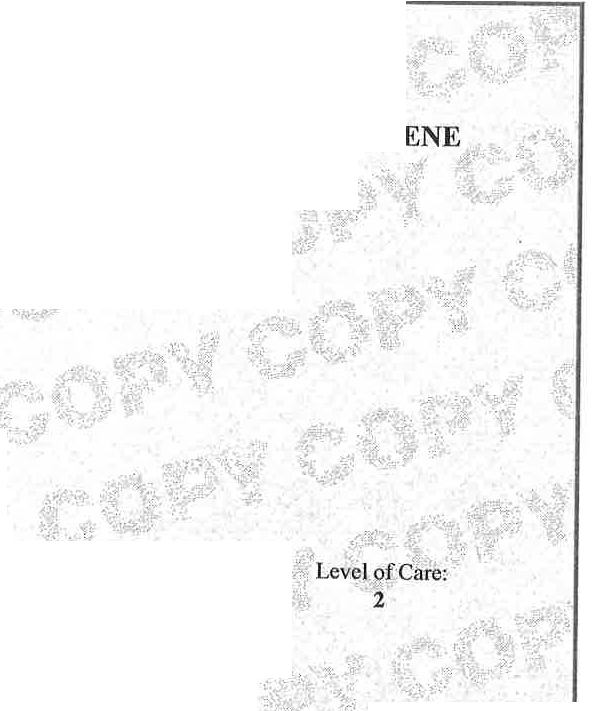
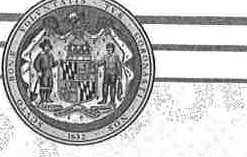
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**STATE OF-MARYLAND·: :·** - *r-;*

**DEPARTMENT OF fil ·ALT AND MENTAL HYGIENE**

**OFFICR..OF aEALTH CARE QUALI1¥**- .:

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BLAND BRY/!NT' S \_l)ILDING

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Litense No. **16AL397-G**

Issued to: Malta, HouseAnc.

T/ \_, Malfa.fl buse - North

49i'6Lasa1Je Road

Hyattsville, MD . 20i82,.l302

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Type o:f Faci lhy or Cmnrnunity Program:

* **sisted Living**

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N 1mbec of Beds: ·

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Date'Jssued: November 8 ZOJ l

TWO YEAR LIC.E.

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**Renewal.Li cens\_e- -** Replaces License #16 97-

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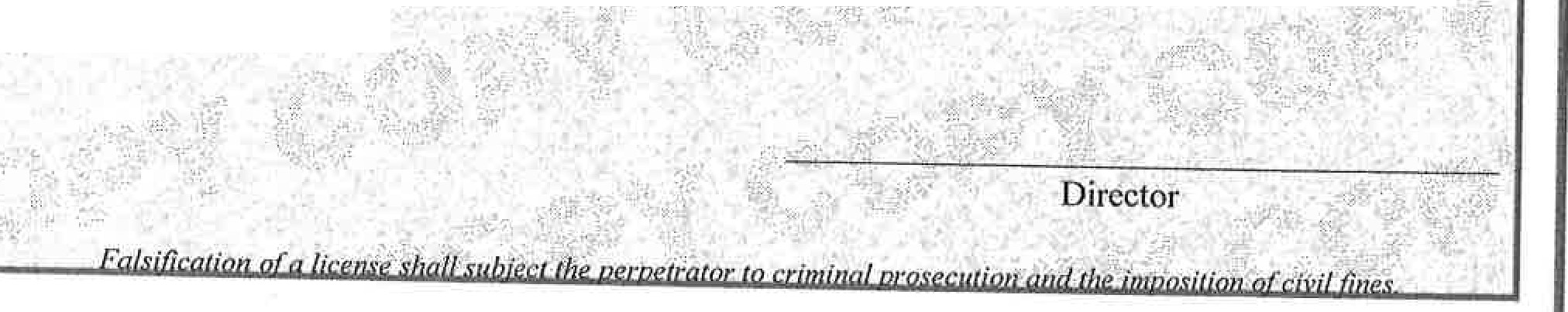
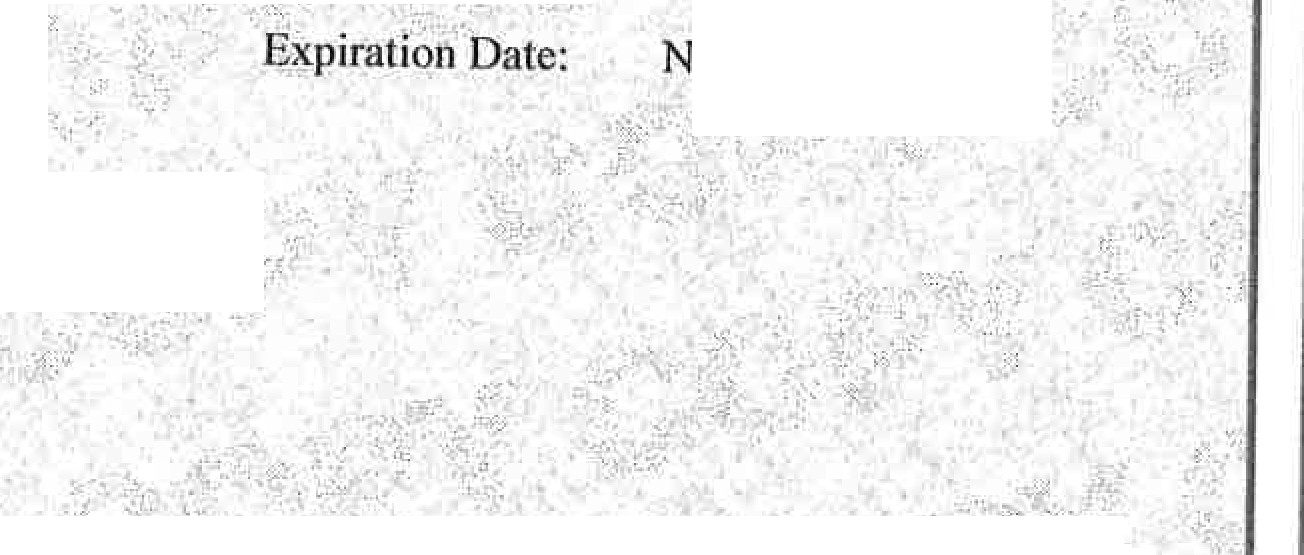
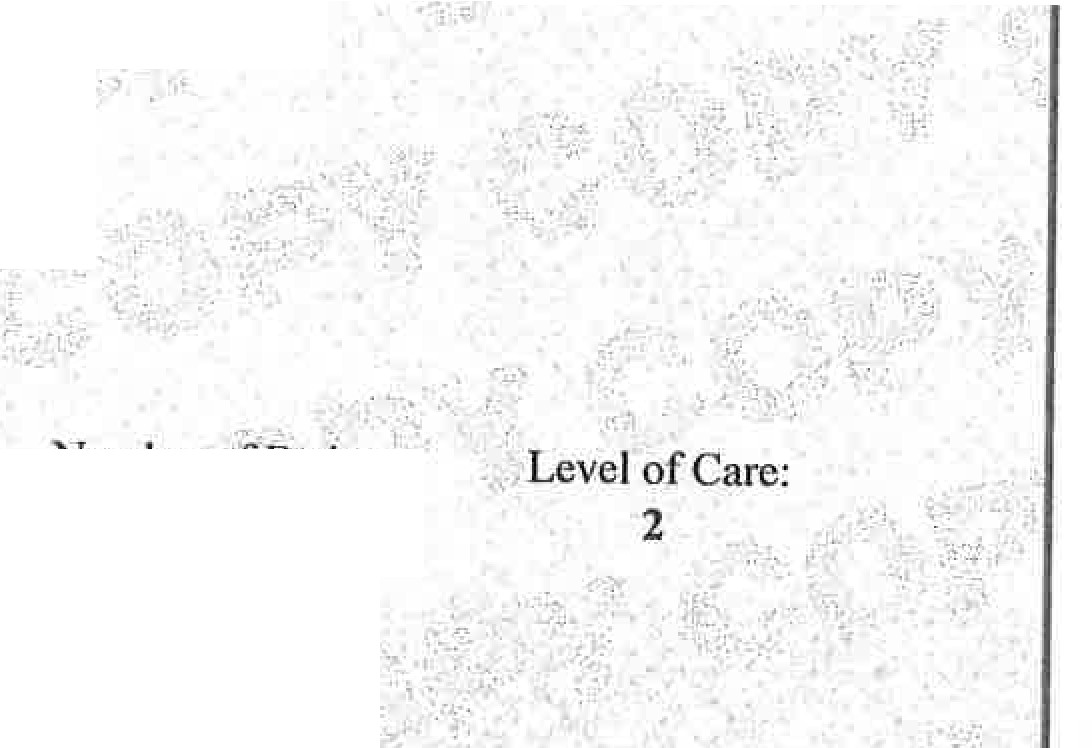
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **16AL397** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING: 2. WING | | (X3) DATE SURVEY COMPLETED  **09/18/2014** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **4916 LASALLE ROAD**  **MALTA HOUSE - NORTH**  **HYATTSVILLE, MD 20782** | | | | | | |
| (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 |
| E 000 | Initial Comments  On September 18, 2014 , a license renewal survey was conducted for the purpose of determining the facility's compliance with COMAR 10.07.14, Assisted Living Program regulation requirements. Survey activities included a tour of the facility, interview of facility residents and employees, the review of two (2) resident records, six (6) administrative records, facility policies/procedures, standards and practices .  The facility census at the time of the survey was fifteen (15) residents.  The facility was determined to be in compliance with the requirements of COMAR 10.07.14, Assisted Living Program regulations. | | E 000 |  | |  |

OHCQ

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

STATE FORM

6899

X3DS11

If continuation sheet 1 of 1

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| --- | --- | --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **16AL397** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING: 2. WING | | (X3) DATE SURVEY COMPLETED  C  **08/07/2014** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **4916 LASALLE ROAD**  **MALTA HOUSE - NORTH**  **HYATTSVILLE, MD 20782** | | | | | | |
| (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 |
| E 000 | Initial Comments  On August 7, 2014 an unannounced complaint investigation was made to the above named facility for the purpose of determining the facility's compliance with COMAR 10.07.14. Survey activities included a review of facility documentation and an interview with the Director.  The facility's census at the time of the survey was 31 residents.  Based on survey findings, in relation only to complaint # MD00085646, the facility was found to be in compliance with COMAR 10.07.14, the regulations governing assisted living programs. | | E 000 |  | |  |

OHCQ

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

STATE FORM

6899

2FY011

If continuation sheet 1 of 1

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **16AL397** | | | (X2) MULTI  A. BUILDIN  B.WING | | PLE  G \_ | CONSTRUCTION  \_ \_ \_ \_ \_ | | | \_ | \_ | (X3) DATE SURVEY COMPLETED  **01/27/2015** | | |
| NAME OF PROVIDER OR SUPPLIER  **MALTA HOUSE** - **NORTH** | | | STREET ADDRESS, CITY, STATE,  **4916 LASALLE ROAD**  **HYATTSVILLE, MD 20782** | | | | | | ZIP | CODE | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | PRIEDFIX TAG | | I | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | | | | C | (XS) OMPLETE  DATE |
| E 000  E3340 | Initial Comments  On 1/23/15, an unannounced complaint investigation was conducted by a representative from the Office of Health Care Quality at the | | | EOOO | | |  | | | | | | | | |
| above named facility in relation to Complaints # MD 00087362, MD 00087791, and MD 00087207  for the purpose of determining the facility's compliance with OMAR 10.07.14, Assisted Living Regulations. Survey activities included resident record reviews, incident reports reviews, review of facility records including activity rosters, interview of staff and residents, and observation of the environment. Based on survey findings, in relation only to complaints #MD 00087362, MD 00087791, and MD 00087207 referral allegations, the following deficiencies were identified on the date of the investigation.  The facility's census at the time of the survey was fifteen (15) residents.  Acronyms which may appear in this report are defined as follows:  ALM: Assisted Living Manager  AALM: Alternate Assisted Living Manager CDS: Controlled Dangerous Substance DN: Delegating Nurse  ALMA: Assisted Living Manager's Assessment HCPPA: Health Care Practitioner's Physical Assessment  MAR: Medication Administration Record RAT: Resident Assessment Tool  SP: Service Plan  .26 83 .26 Service Plan  (3) When the delegating nurse determines in the nurse's clinical judgment that the resident does not require a full assessment within 48 hours, the delegating nurse shall: | | | E3340 | |  | **e\_cE\** E.0  rtB *'"t ·i I,* I  **O**f**'** \ - r\1  ' C'::- L .. .l ; -.,·'., fil; l ·  .- ,. -•,  \-\ea\t\, c·, ,·1--•• | | | | | | | | |

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

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(X6) DATE

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STATE FORM 021199 **X2OS11** If continuation sheet 1 of 4

PRINTED: 02/11/2015 FORM APPROVED

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **16AL397** | | | (X2) MULTIPLE CONSTRUCTION  A. BUILDING \_ \_ \_ \_\_ \_ \_ \_  B. WING \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ | | (X3) | DATE SURVEY COMPLETED  **01/27/2015** | |
| NAME OF PROVIDER OR SUPPLIER  **MALTA HOUSE** - **NORTH** | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **4916 LASALLE ROAD**  **HYATTSVILLE, MD 20782** | | | | | | |
| (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 |
| E3340 | Continued From Page 1 | | | E3340 | | **REC** IVED    omc0 of  Hea\th Care Ouality | | |  |
|  | (a) Document the determination and the reasons | | |  | |
|  | for the determination in the resident's record; and | | |  | |
|  | (b) Ensure that a full assessment of the resident | | |  | |
|  | is conducted within 7 calendar days. | | |  | |
|  | This Requirement is not met as evidenced by: | | |  | |
|  | Based on review of resident's record and DN/CM | | |  | |
|  | interview, the facility failed to provide a detailed, | | |  | |
|  | individualized service plan to ensure resident | | |  | |
|  | needs, as based on assessment, are met. | | |  | |
|  | Findings include: | | |  | |
|  | On 2/6/15 resident #2's service plan was not | | |  | | The service plan of resident #2 was revised 02/06/2015 to include the details of the care provided to  resident #2 to me.et specific needs. (please see attached).  All service plans will be reviewed by | | 02/06/2015 | |
|  | specific to meet . needs. The ALM stated | | |  | |
|  | several things that are being done to meet • | | |  | |
|  | needs; however they are not stated in the service | | |  | |
|  | plan . | | |  | |
| E3420 | .27 D .27 Resident Record or Log | | | E3420 | |
|  | |  | |
|  |  | | |  | | ALM to ensure that details of the | |  | |
|  | D. Resident Care Notes.  (1) Appropriate staff shall write care notes for each resident: | | |  | | care provided to each resident to meet his/her specific needs. | | 04/15/2015 | |
|  | | | |
|  | (a) On admission and at least weekly; | | |  | |
|  | (b) With any significant changes in the resident's | | |  | |
|  | condition, including when incidents occur and | | |  | |
|  | any follow-up action is taken; | | |  | |
|  | (c) When the resident is transferred from the | | |  | |
|  | facility to another skilled facility; | | |  | |
|  | (d) On return from medical appointments and | | |  | |
|  | when seen in home by any health care provider; | | |  | |
|  | (e) On return from nonroutine leaves of absence; | | |  | |
|  | and | | |  | |  | | |  |
|  | (f) When the resident is discharged permanently | | |  | |
|  | from the facility, including the location and | | |  | |
|  | manner of discharge. | | |  | |
|  | (2) Staff shall write care notes that are | | |  | |
|  | individualized, legible, chronological, and signed | | |  | |
|  | by the writer. | | |  | |

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATE FORM 021199 X2OS11 If continuation sheet 2 of 4

PRINTED: 02/11/2015 FORM APPROVED

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **16AL397** | | | (X2) MULTIPLE CONSTRUCTION   1. BUILDING \_ \_ \_\_ \_ \_ \_ \_ 2. WING | | (X3) DATE SURVEY COMPLETED  **01/27/2015** | |
| NAME OF PROVIDER OR SUPPLIER  **MALTA HOUSE** - **NORTH** | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **4916 LASALLE ROAD**  **HYATTSVILLE, MD 20782** | | | | | |
| (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 |
| E3420  E3790 | Continued From Page 2  This Requirement is not met as evidenced by: Based on review of resident's record and intervieVI with the ALM and DN, the facility did not ensure each resident's care notes reflected significant changes in resident's condition including when incidents occur.  Findings include:  Resident #1 had an incident that occurred on 10/11/14 about 8 am documented on the incident report. The care notes dated 10/6/14 -10/12/14 says no visits, no changes.  The nurse practitioner visited resident#1 on 10/16/14 regarding the fall. The care notes dated 10/13/14-10/19/14 states no changes, no falls.  .31 C .31 Incident Reports  C. All incident reports shall include:   1. Time, date, place, and individuals present; 2. Complete description of the incident; 3. Response of the staff at the time; and 4. Notification, including notification to the: 5. Resident, or if appropriate the resident's representative; 6. Resident's physician, if appropriate; 7. Program's delegating nurse; 8. Licensing or law enforcement authorities, when appropriate; and 9. Follow-up activities, including investigation of the occurrence and steps to prevent its reoccurrence.   This Requirement is not met as evidenced by: Based on review of administrative record, the facility did not ensure the incident report included measures to prevent reoccurrence of incident. | | | E3420  E3790 | |  | |  |

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATE FORM 021199 **X20S11** If continuation sheet 3 of 4

PRINTED: 02/11/2015 FORM APPROVED

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **16AL397** B | | | (X2) MULTIPLE CONSTRUCTION  A BUILDING  \_ WING | | (X3) DATE SURVEY COMPLETED  **01/27/2015** | |
| NAME OF PROVIDER OR SUPPLIER  **MALTA HOUSE - NORTH** | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **4916 LASALLE ROAD**  **HYATTSVILLE, MD 20782** | | | | | |
| (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 I (X5) (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE I COMPLETE DEFICIENCY) DATE | | |
| E3790 | Continued From Page 3  Findings include:  There was no documented evidence that preventive measures were put in place on the incident report dated 10/11/14 to prevent a reoccurrence. | | | E3790 | |  | |  |
| Note was made in resident #1 notes to 02/18/2015 to indicate the fall on 10/11/2015.  Nurse Practitione-r was 02/18/2015 | | | | |
|  | | informed that falls need to be documented in her notes during the visit.  Preventive measures were put in place 02/18/2015 for resident #1 to include resident receiving  reminders to take pendant into bathroom when having a shower and informing staff prior to having a shower, so they can stand by.Service plan was revised (see attached).  All incident reports have been reviewed to 02/18/201 include preventive measures. No other  incident report was missing preventive | | |
| measures. The ALM will ensure that all future incident reports include preventive measures. | | |
|  | |  |

5

If deficiencies are cited, an approved plan of correction is requisite to continued program participation .

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STATE FORM 021199 X2OS11 If continuation sheet 4 of 4

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE (DHMH) OFFICEOF Hl:AL1H CARE QUAUTY (OHCQ)

**ASSISTED LIVING**

**RECEIVED**

Form Approved4/4/13 DHMH Form ALAPP.1.1

**Ol.!** · **f 'ln1?**

**1. GENERAL INFORMATION**

**APPLICATION FOR LICENS**

**Office** of

**Ith Care Quality**

CHECK TYPE OF APPLICATION

D Initial I I D Other Change (specify type)DI **[ii**

Renewal Change of Ownership (specify

effective date)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| LICENSE NUMBER (if applicable)  **16AL397-I** | | | | WEBSITE (if applicable}  [**www.victoryhousing.org**](http://www.victoryhousing.org/) | | | | |
| LEGAL AGENCY NAME  Malta House, Inc. | | | | **TRADING NAME (OBA)**  Malta House - North | | | | |
| E-MAIL ADDRESS  **e** [**orchard@victoryhous ing.org**](mailto:orchard@victoryhousing.org) | | | | PHONE NUMBER  **301-699-8600** |  |  | FAX NUMBER  **301-699-1696** | |
| BUSINESS ADDRESS(physical location) Malta House - North | | | | MAILINGADDRESS (if different)  **(same )** | | | | |
| NUMBER, STREET  **4916 LaSalle Road** | | | | NUMBER, STREET |  |  |  | |
| **CITY**  **Hyattsville** | I | STA TE I  **MD** | Z I P  **20782** | CITY |  |  | STATE | ZIP |

Does the owner, corporation, or partnership operate and manage the assisted living program? L Yes No (identify the management structure and its relationship to the business owner)

Victory Housing, Inc., an affiliate of the owner, operates and manages the assisted living program.

NUMBEROF RESIDENTS CURRENTLYSERVED NUMBER OF BEDS REQUESTED LEVELOF CARE REQUESTED

15 15 (remains the same) 0 1 **[ii** 2 0 3

Are all areas of the assisted living facility fully constructed? x Yes No (identify any areas not fully constructed and the extent of construction progress)

|  |  |  |
| --- | --- | --- |
| NAME OF MANAGER  **Elisabeth Orchard** | PHONE NUMBER  **(301) 699-8600** | CELL NUMBER  **(443) 735-7768**  I |
| HOME ADDRESS (number, street)  **6620 Poplar Avenue** | CITY  Takoma Park | STATE ZIP  **MD 20912** |
| NAME OF ALTERNATEMANAGER  **Ann Boitel** | PHONE NUMBER  **301-699-8600** | CELL NUMBER  **301-922-7183**  I |
| HOME ADDRESS (numbe, rstreet)  **10500 Rockville Pike, #313** | CITY  **Rockville** | STATE ZIP  **MD 20852** |
| NAME OF DELEGATING NURSE (ON)  **Robyn Blake** | PHONE NUMBER  **(301) 699-8600** | CELL NUMBER  **(442) 579-5557**  I |
| HOME ADDRESS (numbe,r street) 401 Signal Court | CITY  **Bel Air** | STATE ZIP  **MD 21014** |
| DN'S LICENSE NUMBER  **R166864** | EXPIRATION DATE OF DN'S LICENSE  **2/28/2018** | |

Is your facility planning to operate, or currently operating, an "Alzheimer's Special Care Unit or Program?" No

D Yes (refer to the instruction guide for details on submitting your program description)

**2. FEES t** ') 0 . 0 0 9 - **7 - ll O l** 5 *L{* k,

To determine the amount of the **non-refundable** license fee and accepted methods of payment, refer to the instruction guide.

FEE ATTACHED? Ii] Yes

DHMH Form AL.APP.1.1 (4/13)

1. **!)WNERSHIP** (Type of business organization of disclosing entity)

SOLE PROPRIETORSHIP PARTNERSHIP *x* CORPORATION

NAME ADDRESS

Malta House, Inc. 4916 LaSalle Road, Hyattsville, MD 20782

IF PARTNERSHIP OR CORPORATION,

PARTNER, OFFICER, DIRECTOR, OR STOCKHOLDER INFORMATION AND PERCENTAGE OWNED IF 25% OR MORE

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NAME AND TITLE  : | E-MAIL | PHONE  NUMBER | ADDRESS | ·%  OWNED |
| See Attached |  |  |  | 0 |
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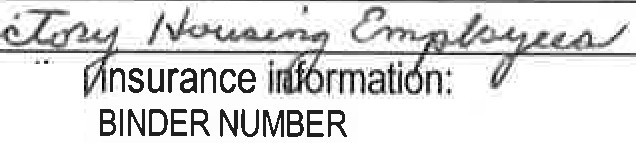
IF CORPORATION: DATE OF CHARTER 2/5/1993

DATE OF INCORPORATION 2/11/1993

|  |  |  |  |
| --- | --- | --- | --- |
| NAME OF PRESIDENT  Leila A. Finucane | PHONE NUMBER (301) 493-6000 |  | CELL NUMBER |
| ADDRESS (number,street)  11400 Rockville Pike, Suite 505 | CITY  Rockville | | STATE ZIP  MD 20852 |

1. **BACKGROUND**
2. Has the applicant, owner, or managerial staff ever had a license, permit, or certificate to provide care to third parties that has been denied, suspended, or revoked? **[j]** No D Yes (explain)
3. Does the applicant currently hold, or has the applicant previously held, any llcense or certification for the operation of a health care facility or similar health care program? D No **[j]** Yes (explain)

Victory Housing, Inc. currently manages 7 other assisted living homes.



Do ou have an em lo ees? **ii** Yes D No ·

If you answered YES, provide your workers' compensatio

POLICY NUMBER

1. Does the owner, applicant, manager, alternate manager, other staff, or any household member have a criminal conviction or other criminal history? **[j]** No D Yes (explain)
2. **WORKERS' COMPENSATION**

|  |  |
| --- | --- |
| 7164-91-30 |  |
| INSURANCE COMPANY  BF Saul Insurance Company | EFFECTIVE DATE EXPIRATION DATE  7/1/2017 7/1/2018 |

If you answered NO, additional documentation from the Workers' Compensation Commission must accompany this

application (refer to the instruction guide for details).

1. **AFFIDAVIT**

I solemnly affirm under the penalties of perjury and upon personal knowledge that the contents of the foregoing application are true. I understand that the falsification of an application for a license may subject me to criminal prosecution, civil money penalties, and/or the revocation of any license issued to me by the DHMH. In addition, knowingly and willfully failing to fully and accurately disclose the requested information may result in denial of a request to become licensed or, where the entity already is licensed, a revocation of that license.

I certify that this agency is in compliance with administrative and procedural requirements pertaining to the Assisted Living Programs Code of Maryland Regulations (COMAR 10.07.14.)

I further certify that I will notify the OHCQ if there are any future substantive changes in agency and operation, and that written notice will be given before the effective date of the change.

I hereby swear and affirm that I am over the age of 21 and I am otherwise competent to sign this Affidavit.

DHMH FonnAL.APP.1.1 (4/13)

*If the program is going to be in more than one applicant's name, each applicant's signature is required.*

|  |  |  |  |
| --- | --- | --- | --- |
|  | | TITLE  **1 ct.\_ {--** | DAT/E /.  ***f I :f* / *2-?t =I--*** |
| SIGNATUREOF APPLICANT |  | TITLE | DATE |
| SIGNATURE OF APPLICANT |  | TITLE | DATE |
| **FOR OFFICE USE O LY** | | | |
| L C'E SE N0MBER | FEI:  $ | CHECKM/ O | CHEGK/MO [)ATE |

DHMH Form ALAPP .1.1 (4/13) 3

# STATE OF MARYLAND

***Department of Assessments and Taxation***

I, MICHAEL L. HIGGS OF THE STATE DEPARTMENT OF ASSESSMENTS AND TAXATION OF THE STATE OF MARYLAND, DO HEREBY CERTIFY THAT THE DEPARTMENT, BY LAWS OF THE STATE, IS THE CUSTODIAN OF THE RECORDS OF THIS STATE RELATING TO THE

FORFEITURE OR SUSPENSION OF CORPORATIONS, OR THE RIGHTS OF CORPORATIONS TO TRANSACT BUSINESS IN THIS STATE, AND THAT I AM THE PROPER OFFICER TO EXECUTE THIS CERTIFICATE.

I FURTHER CERTIFY THAT MALTA HOUSE, INC. (D03598158), INCORPORATED FEBRUARY 11, 1993, IS A CORPORATION DULY INCORPORA TED AND EXISTING UNDER AND BY VIRTUE OF THE LAWS OF MARYLAND AND THE CORPORATION HAS FILED ALL ANNUAL REPORTS REQUIRED, HAS NO OUTST.ANDING LATE FILING PENALTIES ON THOSE REPORTS, AND HAS A RESIDENT AGENT. THEREFORE, THE CORPORATION IS AT THE TIME OF THIS CERTIFICATE IN GOOD STANDING WITH THIS DEPARTMENT AND DULY AUTHORIZED TO EXERCISE ALL THE POWERS RECITED IN ITS CHARTER OR CERTIFICATE OF INCORPORATION, AND TO TRANSACT BUSINESS IN MARYLAND.

IN WITNESS WHEREOF, I HAVE HEREUNTO SUBSCRIBED MY SIGNATURE AND AFFIXED THE SEAL OF THE STATE DEPARTMENT OF ASSESSMENTS AND TAXATION OF MARYLAND AT BALTIMORE ON THIS SEPTEMBER 07, 2017.

**Michael L. Higgs**

**Director**

*301 West Preston Street, Baltimore, Maryland 21201*

*Telephone Ba/to. Metro (410) 767-1340 I Outside Ba/to. Metro (888) 246-5941 MRS (Maryland Relay Service) (800) 735-2258 TT/Voice*

0010747997

**MALTA HOUSE, INC.**

**BOARD OF DIRECTORS** & **OFFICERS**

2017

BOARD OF DIRECTORS

**REV. MSGR. BARRY KNESTOUT**

Moderator of the Curia Archdiocese of Washington 5001 Eastern Avenue

Hyattsville, MD 20782-3447

**PAULE. JOHNSON, Jr.**

4502 Tournay Road

Bethesda, MD 20816-1843

**ERIC SIMONTIS**

Chief Financial Officer Archdiocese of Washington 5001 Eastern Avenue

Hyattsville, MD 20782-3447

OFFICERS

**LEILA A. FINUCANE, CEO/PRESIDENT**

11400 Rockville Pike, Suite 505

Rockville, MD 20852

**SISTER IRENE DUNN, VICE PRESIDENT**

11400 Rockville Pike, Suite 505

Rockville, MD 20852

**JOHN D. SPENCER, SECRETARY**

11400 Rockville Pike, Suite 505

Rockville, MD 20852

**JEFFREY BLACKWELL, ASSISTANT SECRETARY**

11400 Rockville Pike, Suite 505

Rockville, MD 20852

**KATHLEEN MCWILLIAMS, TREASURER**

11400 Rockville Pike, Suite 505

Rockville, MD 20852

Page 1 of 1

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE (DHMH) OFFICE OF HEALTH CARE QUALITY (OHCQ)

**ASSISTED LIVING**

**Office** ofForm Approved 4/4/13

**Health** Gare elJ MM:r . PP1.1

1. **GENERAL INFORMATION**

CHECK TYPE OF APPLICATION

###### APPLICATION FOR LICENSURE

D Initial I **[i]** Renewal I D Change of Ownership (specify I D Other Change (specify type)

effective **date)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| LICENSE **NUMBER** (if applicable)  **16AL397** | | | | | **WEBSITE (if** applicable)  [**www.victoryhousing.org**](http://www.victoryhousing.org/) | | | |
| **LEGAL AGENCY NAME**  **Malta House, Inc.** | | | | | **TRADING NAME (OBA)**  **Malta House** - **North** |  | | |
| **E-MAIL** ADDRESS  **e** [**orchard@victoryhousing.org**](mailto:orchard@victoryhousing.org) | | | | | **PHONENUMBER**  **301-699-8600** |  | FAX NUMBER  **301-699-1696** | |
| **BUSINESS ADDRESS (physical** location)  **Malta House** - **North** | | | | | **MAILING ADDRESS** (If **different)**  **(same)** | | | |
| **NUMBER,** STREET  **4916 La Salle Road** |  |  |  |  | **NUMBER, STREET** |  |  | |
| **CITY**  **Hyattsville** |  | STATE  **MD** |  | ZIP  **20782** | CITY |  | STATE | **ZIP** |

Does the owner, corporation, or partnership operate and manage the assisted living program? L Yes No (identify the management structure and its relationship to the business owner)

Victory Housing, Inc., an affiliate of the owner, manages the assisted living program.

NUMBER OF RESIDENTS CURRENTLYSERVED NUMBER OF BEDS REQUESTED LEVEL OF CARE REQUESTED

15 15 (remains the same) D 1 **[i]** 2 D 3

Are all areas of the assisted living facility fully constructed? *x* Yes No (identify any areas not fully constructed and the extent of construction progress)

|  |  |  |
| --- | --- | --- |
| NAME OF MANAGER  **Elisabeth Orchard** | PHONE NUMBER  **(301**) **699-8600** | CELL NUMBER  **(443) 735-7768**  I |
| HOME ADDRESS (number, **street)**  **6620** Poplar **Street** | CITY  **Takoma** Park | STATE ZIP  **MD 20912** |
| **NAME OF** ALTERNATE MANAGER  **Ann Boitel** | PHONE NUMBER  **301-699-8600** | CELL **NUMBER**  **301-922-7183**  I |
| **HOME ADDRESS** (number, **street)**  **10500 Rockville Pike #313** | CITY  **Rockville** | STATE ZIP  **MD 20852** |
| **NAME**OF DELEGATINGNURSE (DN)  **Olpha Okero** | PHONE NUMBER  **(301) 699-8600** | **CELL NUMBER**  **(651) 786-9722**  I |
| HOME **ADDRESS (nmu ber, street)**  **8344 Linda Court #2B** | CITY  **Jessup** | STATE ZIP  **MD 20794** |
| DN'S LICENSE NUMBER  **R198283** | EXPIRATION **DATE OF DN'S** LICENSE  **01/28/2016** | |

Is your facility planning to operate, or currently operating, an "Alzheimer's Special Care Unit or Program?" No

D Yes (refer to the instruction guide for details on submitting your program description)

1. **FEES**

To determine the amount of the **non-refundable** license fee and accepted methods of payment, refer to the instruction guide.

FEE ATTACHED? **[i]** Yes

DHMH Form AL.APP.1.1 (4/13)

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1. **OWNERSHIP** (Type of business organization of disclosing entity)

SOLE PROPRIETORSHIP PARTNERSHIP x CORPORATION

NAME ADDRESS

Malta House, Inc. 4916 La Salle Road, Hyattsville, MD 20782

IF PARTNERSHIP OR GORPORA TION,

PARTNER, OFFICER, Dl ECTOR, OR STOCKHOLDER INFORMATION AND PERCENTAGE OWNED IF 25% OR MORE

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NAME AND TITLE  l | E-MAIL | PHONE  NUMBER | ADDRESS | %  OWNED |
| See Attached |  |  |  | 0 |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

IF CORPORATION: DATE OF CHARTER 02/05/1993

DATE OF INCORPORATION 02/11/1993

|  |  |  |  |
| --- | --- | --- | --- |
| NAME OF PRESIDENT  James A. Brown, Jr. | PHONE NUMBER (301) 493-6000 |  | CELL NUMBER |
| ADDRESS (number, street)  11400 Rockville Pike, Suite 505 | CITY  Rockville | | STATE ZIP  MD 20852 |

1. **BACKGROUND**
2. Has the applicant, owner, or managerial staff ever had a license, permit, or certificate to provide care to third parties that has been denied, suspended, or revoked? Iii No D Yes (explain)
3. Does the applicant currently hold, or has the applicant previously held, any license or certification for the operation of a health care facility or similar health care program? D No Iii Yes·(explain)

Management company oversees 7 other assisted living homes.

1. Does the owner, applicant, manager, alternate manager, other staff, or any household member have a criminal conviction or other criminal history? Iii No D Yes (explain)
2. **WORKERS' COMPENSATION**

Do you have any employees? Iii Yes D No

If you answered YES, provide your workers' compensation insurance information:

POLICY NUMBER BINDER NUMBER

|  |  |
| --- | --- |
| **7164-91-30** |  |
| INSURANCE COMPANY  BF Saul Insurance Company | EFFECTIVE DATE EXPIRATION DATE  07/01/2015 07/01/2016 |

If you answered NO, additional documentation from the Workers' Compensation Commission must accompany this application (referto the instruction guide for details).

1. **AFFIDAVIT**

I solemnly affirm under the penalties of perjury and upon personal knowledge that the contents of the foregoing application are true. I understand that the falsification of an application for a license may subject me to criminal prosecution, civil money penalties, and/or the revocation of any license issued to me by the DHMH. In addition, knowingly and willfully failing to fully and accurately disclose the requested information may result in denial of a request to become licensed or, where the entity already is licensed, a revocation of that license.

I certify that this agency is in compliance with administrative and procedural requirements pertaining to the Assisted Living Programs Code of Maryland Regulations (COMAR 10.07.14).

I further certify that I will notify the OHCQ if there are any future substantive changes in agency and operation, and that written notice will be given before the effective date of the change.

I hereby swear and affirm that I am over the age of 21 and I am otherwise competent to sign this Affidavit.

DHMH Form ALAPP.1.1 ('1/13)

*If the program is going to be in more than one applicant's name, each applicant's signature is required.*

|  |  |  |
| --- | --- | --- |
| SIGNATURE OF APPLICANT 9 | TITLE **Pi**  **r.c.s *1J* e,.,.. f** | DATE ***, (1,( 1,1{*** |
| SIGNATURE OF APPLICANT | TITLE | DATE |
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**FOR OfflCE llJSE ONLV**

LICENSE NL/ ER

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DHMH Form AL.APP.1.1 (4/13)

***STATE OF MARYLAND***



***Department of Assessments and Taxation***

I, PAUL B. ANDERSON OF THE STATE DEPARTMENT OF ASSESSMENTS AND TAXATION OF THE STATE OF MARYLAND, DO HEREBY CERTIFY THAT THE DEPARTMENT, BY LAWS OF THE STATE, IS THE CUSTODIAN OF THE RECORDS OF THIS STATE RELATING TO THE

FORFEITURE OR SUSPENSION OF CORPORATIONS, OR THE RIGHTS OF CORPORATIONS TO TRANSACT BUSINESS IN THIS STATE, AND THAT I AM THE PROPER OFFICER TO EXECUTE THIS CERTIFICATE.

I FURTHER CERTIFY THAT MALTA HOUSE, INC., INCORPORATED FEBRUARY 11, 1993, IS A CORPORATION DULY INCORPORATED AND EXISTING UNDER AND BY VIRTUE OF THE LAWS OF MARYLAND AND THE CORPORATION HAS FILED ALL ANNUAL REPORTS REQUIRED, HAS NO OUTSTANDING LATE FILING PENALTIES ON THOSE REPORTS, AND HAS A RESIDENT AGENT. THEREFORE, THE CORPORATION IS AT THE TIME OF THIS CERTIFICATE IN GOOD STANDING WITH THIS DEPARTMENT AND DULY AUTHORIZED TO EXERCISE ALL THE POWERS RECITED IN ITS CHARTER OR CERTIFICATE OF INCORPORATION, AND TO TRANSACT BUSINESS IN MARYLAND.

IN WITNESS WHEREOF, I HAVE HEREUNTO SUBSCRIBED MY SIGNATURE AND AFFIXED THE SEAL OF THE STATE DEPARTMENT OF ASSESSMENTS AND TAXATION OF MARYLAND AT BALTIMORE ON THIS SEPTEMBER 30, 2015.



Paul B. Anderson Charter Division



crblnk

*301 West Preston Street, Baltimore, Maryland 21201*

*Telephone Ba/to. Metro (410) 767-1340 I Outside Ba/to. Metro (888) 246-5941 MRS (Maryland Relay Service) (800) 735-2258 TT/Voice*

*Fax (410) 333-7097* R0009834072



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#### MALTA HOUSE, INC.

**BOARD OF DIRECTORS** & **OFFICERS**

##### 2016

BOARD OF DIRECTORS

**REV. MSGR. BARRY KNESTOUT**

Secretary for Pastoral Ministry and Social Concerns

Archdiocese of Washington 5001 Eastern Avenue

Hyattsville, MD 20782-3447

**PAULE. JOHNSON, Jr.**

4502 Tournay Road

Rockville, MD 20816-1843

**THOMAS P. DUFFY**

Chief Financial Officer Archdiocese of Washington 5001 Eastern Avenue

Hyattsville, MD 20782-3447

OFFICERS

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11400 Rockville Pike, Suite 505

Rockville, MD 20852

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Rockville, MD 20852

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Rockville, MD 20852

**KATHLEEN MCWILLIAMS, TREASURER**

11400 Rockville Pike, Suite 505

Rockville, MD 20852

Page 1 of 1

(Tags:  Trial attorney, nursing home lawyer, nursing home attorney, overmedication, 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, Maryland abuse attorney, Prince Georges County Nursing Home, nursing home 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, Maryland abuse attorney, silver spring nursing home attorney, wrongful death, pressure sores, at Malta House, Malta House North, Hyattsville )