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

Forestville Healthcare Center (Formerly
Forestville Health and Rehabilitation Center)
7420 Marlboro Pike
Forestville, MD 20747

Characteristics:

- A For-Profit Company with 162 Beds
- Legal Business Name – Marlboro Leasing Co, LLC
- www.communicarehealth.com/facility/forestville-healthcare-center/
- Operational/Managerial Control – Richard Odenthal
- Managing Employee – Dodlyn Buck

As of August 2020, Forestville Healthcare Center is rated as a three-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 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 Forestville Healthcare Center in Forestville, 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 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 Forestville Healthcare Center 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.

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, and some results may have changed upon appeal, which may not be noted here.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215020	A. BUILDING _____ B. WING _____	**02/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FORESTVILLE HEALTHCARE CENTER	**7420 MARLBORO PIKE FORESTVILLE, MD 20747**

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 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on review of medical record and interview with facility staff, it was determined that the facility failed to ensure that residents with multiple orders for as-needed pain medication had orders that specified when those medications were to be administered, and that such parameters were followed when the medication was administered. This was evident for 1 (Resident #5) of 6 residents reviewed during the complaint survey. The findings include: Resident # 5's medical record was reviewed on 2/14/20 at 9:34 AM. During the review, it was found that the resident had three orders for as-needed pain medication: 1) [MEDICATION NAME] tablet 325mg, give 2 tablets by mouth every 6 hours as needed for mild pain, 2) [MEDICATION NAME] tablet 500mg, give 1 tablet by mouth every 6 hours as needed for moderate pain, and 3) [MEDICATION NAME] HCl tablet 50mg, give 1 tablet by mouth every 6 hours as needed for pain. Although the two orders for [MEDICATION NAME] (Tylenol) both had parameters of mild pain and moderate pain, the lower dose specified a higher level of pain and the higher dose specified a lower level of pain. There was no parameter for the [MEDICATION NAME] order. Parameters are used in medication orders to specify when a given medication should or should not be given. When a resident has orders for multiple pain medications, parameters communicate a physician's intention as to which medication should be administered for certain types or levels of pain. In the case of levels of pain, it is often helpful to measure pain on a scale of 1-10, in which 1 is nearly no pain and 10 is the worst pain of a person's life. Mild pain is usually considered to be pain levels 1-3, moderate pain to be 4-6, and severe pain to be 7-10. Review of Resident #5's Medication Administration Record [REDACTED]. Review of the MAR for (MONTH) of 2019 revealed that the [MEDICATION NAME] order for moderate pain was given for a pain level of 2 (5/31/19). Review of the MAR for (MONTH) of 2019 revealed that the [MEDICATION NAME] order for moderate pain was given for a pain level of 3 (7/17/19), and that [MEDICATION NAME] was given for a pain level of 3 (7/27/19). The Administrator and Director of Nursing (DON) were interviewed on 2/14/20 at 10:40 AM. During the interview, the Administrator and DON acknowledged that the administrations noted above did not meet their expectation of how those medications should have been administered.

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215020	A. BUILDING _____ B. WING _____	**06/24/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FORESTVILLE HEALTHCARE CENTER	**7420 MARLBORO PIKE FORESTVILLE, MD 20747**

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined the facility staff failed to ensure all resident rooms and hallways were maintained in a homelike manner. This was evident for 11 of 19 rooms reviewed during the survey. The findings include: 4. During an initial tour of the facility on 6/19/19 at 10:00 AM, observations revealed the blinds in the windows of rooms [ROOM NUMBER] were damaged. In all three rooms, the edges of the blinds were bent on both sides of the windows. This damage prevented the window blinds from blocking light coming into the room. One of the two residents in room [ROOM NUMBER] expressed in interview with the surveyor that the blinds were horrid and agreed that they detracted from the homelike environment of the room. The Director of Maintenance was made aware. Further observations of the facility revealed the following: 1. A hole near the base of the wall behind the door in room [ROOM NUMBER]. The hole was over one (1) foot in width. The bathroom door and the walls adjoining the door had scrape marks. The right wall facing the outside hall had scrape marks as well. 2. A hole in the wall behind the door in room150. Scrape marks on the bathroom door and wall. 3. The corner of the wall across from the nursing station was in disrepair, and the alcove door had scrape marks on it. 4. Missing paint on the lower wall by the window in room [ROOM NUMBER]. 5. The closet door in room [ROOM NUMBER] (bed A) did not have handles or knob to assist residents and staff in opening and the closet. 6. Missing paint behind bed A in room [ROOM NUMBER]. 7. Damaged dry wall by window in room [ROOM NUMBER] (bed A). 8. Patches of paint missing from the bathroom door in room [ROOM NUMBER]. 9. Exposed dry wall which requires paint in room [ROOM NUMBER]. On 6/24/2019 at 1:25 PM staff # 11 (Maintenance Director) and the administrator were made aware of the issues.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview it was determined the facility failed to correctly code the Minimum Data Set (MDS) for Residents #153 and #68. This was evident for 2 of 46 residents investigated during the survey. The Minimum Data Set (MDS) is a core set of screening questions that provide the foundation for the RAI process. Providers must complete the MDS screening assessments at specified times during resident admissions. Some MDS assessments are comprehensive and others are abbreviated updates to the comprehensive assessments. After completion of any comprehensive MDS assessment, the MDS triggers care areas based on the responses to the MDS questions (also referred to as MDS Items). Each triggered care area must then be assessed in order to determine if care planning is needed. The MDS triggers are used to provide direction for the development of an effective plan that will ensure the assessed needs of each resident are met when care is delivered. The MDS is a key tool in the process of assessing the capabilities of residents in a nursing care facility. MDS Coordinators are the certified individuals who take these assessments and use the results to formulate individual care plans for residents. The Resident Assessment Instrument (RAI) is a mandated process that ensures residents in nursing homes receive comprehensive and periodic assessments that are both standardized and reproducible to ensure each resident's needs are clearly understood and that care can be appropriately and effectively planned and delivered (based on the assessment). The findings include: 1. A review of Resident #153's medical record revealed the resident was admitted to the facility on [DATE], then discharged to his/her home on 5/7/19. A review of MDS, dated [DATE], stated resident #153 was hospitalized , not discharged home. On 06/24/2019 at approximately 11:23 AM Staff #12, an MDS coordinator, was interviewed. Staff #12 stated she will make the changes to the MDS. The Administrator was made aware on 6/24/19 at 2:30 PM. 2. On 06/24/2019 resident #68's MDS assessment, dated 02/18/2019, was reviewed. The review revealed; that Resident #68 was admitted to facility with multiple medical [DIAGNOSES REDACTED]. On 02/02/19 Resident #68 began receiving hospice services. Continued record review of the assessment revealed that on 02/04/19 the facility coded, NO, for chronic health condition which will result in end of life expectance less than 6 month (Section J -Health Condition J-1400). The facility did not code the resident's hospice status for in Section O-1000, this section was blank. On 6/24/19 at 3:00 PM the Administrator was interviewed. The Administrator confirmed the assessment error.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and interviews it was determined that the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives to meet the medical, nursing, mental and psychosocial needs for 1 out of 39 residents (Resident #68) reviewed during investigative portion of the annual survey. A plan of care is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of resident care. The finding includes: On 6/24/19 at 1:30 p.m. Resident #68's medical record was reviewed. The review revealed an assessment dated in (MONTH) 2012. According to the assessment, Resident#68 scored a three (3) out of 15 on his/her Brief Interview for Mental Status (BIMS), which signifies mental impairment and inability to make decisions. Further review of the record revealed that on 2/2/19 Resident #68 experienced a change in condition and was given a new medical diagnosis. The resident was also admitted to hospices services and given new physician orders [REDACTED].

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215020	A. BUILDING _____ B. WING _____	06/24/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FORESTVILLE HEALTHCARE CENTER	7420 MARLBORO PIKE FORESTVILLE, MD 20747

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) On 6/24/19 at 1:30 p.m. Resident #68's care plan was reviewed. The review revealed the facility did not develop a care plan after Resident #68 experienced a change in physical condition. The continued review of the record revealed that the facility's nursing staff failed to develop a care plan with intervention to address the new medical diagnosis. On 6/24/19 at 3:00 p.m. The Administrator was interviewed. The Administrator confirmed the care plan did not address Resident #68's new medical diagnosis.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** Based on review of resident records and interview with facility staff, it was determined that the facility failed to ensure that residents' plans of care were reviewed and revised by the interdisciplinary team at least quarterly. This was evident for 1 of 2 residents reviewed for care plans (Resident #103). The findings include: Resident #103 was interviewed on 6/20/19 at 9:40 AM. During the interview, the resident states that s/he does not receive quarterly care plan meetings. Resident #103's electronic medical record was reviewed on 6/24/19 at 1:15 PM. During the review, notes were found from meetings that took place on 5/14/19, 8/14/18, and 1/30/18. No meeting note could be found in the electronic record that established that a meeting had taken place between 8/14/18 and 5/14/19. Resident #103's paper medical record was reviewed on 6/24/19 at 2:30 PM. During the review, sign in sheets were found for meetings that took place on 5/14/19, 8/14/18, and 4/25/18. Again, no meeting sign in sheet could be found that established that a meeting had taken place between 8/14/18 and 5/14/19. The Director of Nursing (DON) was interviewed on 6/24/19 at 3:15 PM. During the interview, the DON was made aware of the findings from the paper and electronic medical record and was asked to provide any evidence of a care planning meeting for Resident #103 being scheduled or taking place between 8/14/18 and 5/14/19. None was provided by the conclusion of the survey.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview it was determined facility staff failed to maintain an environment free of unnecessary accident hazards as evidenced by: 1) Residents #1, #35 and #84 using their own lighters during a smoke break while Resident #46 was being observed; and 2) a medication cart that was found unlocked and unattended. Observations of the residents smoking were evident during 2 smoking breaks. The findings regarding the medication cart were noted on 1 of 4 days of observation during the survey. The findings include: 1. On 6/20/19 during the 9:15 AM smoke break Resident #46 was being observed for smoking safety. The writer noted that as the residents went outside to smoke, before staff could light all the cigarettes, Residents #1, 35, and 84 pulled out their own lighters, lit their cigarettes and proceeded to light other residents' cigarettes. Writer informed staff outside with the Residents. On 6/21/19 prior to the 9:15 AM smoke break the writer observed the 1st floor unit manager asking Residents #1 and 84 if they had any lighters to which they replied no. Resident #35 was not among the group. When the Residents went out to smoke, Resident #35 pulled out a lighter and lit his/her own cigarettes. Again, the staff were made aware. Residents in procession of their own cigarette lighters puts the facility at risk for safety issues. 2. During an observation that took place on 6/21/19 at 1:24 PM, a medication cart was found to be unlocked and unattended in the hallway outside of room [ROOM NUMBER]. Resident #87 was noted to be in his/her wheelchair, apparently asleep, facing the unlocked cart but about 30 feet away. No staff were in the hallway at that time. The surveyor remained near the cart until three minutes later (at 1:27 PM), licensed practical nurse #9 walked past the cart, locked it, and then turned into room [ROOM NUMBER]. The medication cart contained most of the daily medicines for a range of resident rooms on the second level of the facility. No other medication carts were noted to be unlocked and unattended during the survey. 2. During an observation that took place on 6/21/19 at 1:24 PM, a medication cart was found to be unlocked and unattended in the hallway outside of room [ROOM NUMBER]. Resident #87 was noted to be in his/her wheelchair, apparently asleep, facing the unlocked cart but about 30 feet away. No staff were in the hallway at that time. The surveyor remained near the cart until three minutes later (at 1:27 PM), licensed practical nurse #9 walked past the cart, locked it, and then turned into room [ROOM NUMBER]. The medication cart contained most of the daily medicines for a range of resident rooms on the second level of the facility.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview it was determined staff failed to: 1) clarify an order for [REDACTED]. The findings include: On 6/24/19 beginning at approximately 11:00 AM, the medical record of Resident #402 was reviewed. During the review, it was noted that Resident #402 had an order for [REDACTED]. According to drugs.com (website https://www.drugs.com/[MEDICATION NAME].htm), [MEDICATION NAME] is an opioid pain medication sometimes called a narcotic. [MEDICATION NAME] is used to treat moderate to severe pain. It is a minimum standard of nursing practice that nursing staff are to clarify orders that are unclear. During the same medical record review, the (MONTH) 2019 Medication Administration Record [REDACTED]. It was noted Resident #402 was given [MEDICATION NAME] HCL 5 mg once on the 22nd and once on the 24th. Documentation of a thorough pain assessment was found on an electronic facility form titled Pain Assessment Tool V5 for the as needed [MEDICATION NAME] administered on the 24th but was not found for the 22nd. The Director of Nursing (DON) was interviewed on 6/24/219. According to the DON, each time nursing staff administer as needed pain medication for moderate or severe pain, they are supposed to document a thorough pain assessment on this form.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident medical records, it was determined that the facility failed to ensure that pharmacy record reviews were acted on in a timely manner. This was evident for 1 of 6 residents (Resident #123) reviewed for unnecessary medications. The findings include: Resident #123's medical record was reviewed on 6/21/19 at 10:57 AM. During the review, it was found that consultant pharmacist recommendations were made on 5/13/19 around the time of the resident's admission to the facility. One of the recommendations made on 5/13/19 was related to an anticoagulant medication that had been prescribed for illness prevention ('[MEDICATION NAME]'). The recommendation stated, Please clarify as this appears to be a full therapeutic dose as opposed to a [MEDICATION NAME] dose. The physician response stated, ([MEDICATION NAME]) dose, and was signed on 5/15/19. A follow up note was written that stated Discontinued on 5/28/19, continued on another anticoagulant. This represented a delay from the from the physician's response on 5/15/19 to the discontinuation of the medication on 5/28/19.

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	215020	A. BUILDING _____ B. WING _____	**06/24/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FORESTVILLE HEALTHCARE CENTER	**7420 MARLBORO PIKE FORESTVILLE, MD 20747**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) A second of the recommendations made on 5/13/19 was related to [MEDICATION NAME], which is often used for heart failure or irregular heartbeat. The recommendation stated, Please clarify (indication). [MEDICATION NAME] is not used for (blood pressure), and I see no other [DIAGNOSES REDACTED]. The physician response stated, (Discontinue) [MEDICATION NAME], and was signed on 5/15/19. A follow up note was written that stated, Dose was discontinued on 5/31/19. This represented a delay from the physician's response on 5/15/19 to the discontinuation of the medication on 5/31/19.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview it was determined there was an error in the diagnostic list in the Admission Record for 1 of 46 residents investigated during the survey (Resident #35). The findings include: On 6/21/19 at 10:08 AM A review of Resident #35's medical record revealed a [DIAGNOSES REDACTED]. According to information on Mayo Clinic website https://www.mayoclinic.org/diseases-conditions/diabetes-insipidus/symptoms-causes/syc- 269: Diabetes insipidus (die-uh-BEE-teze in-SIP-uh-dus) is an uncommon disorder that causes an imbalance of fluids in the body. This imbalance makes you very thirsty even if you've had something to drink. It also leads you to produce large amounts of urine. While the terms diabetes insipidus and diabetes mellitus sound similar, they're not related. Diabetes mellitus - which can occur as type 1 or type 2 - is the more common form of diabetes. Further review of the medical record revealed no ordered lab tests or medications that would be associated with a [DIAGNOSES REDACTED]. At approximately 10:30 AM, staff nurse #1 was asked to clarify the [DIAGNOSES REDACTED]. On 6/24/19 at about 9:45 AM, the Administrator and Director of Nursing (DON) both stated the [DIAGNOSES REDACTED].#35 had Type 2 diabetes mellitus and the [DIAGNOSES REDACTED].

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	215020	A. BUILDING _____ B. WING _____	04/16/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on medical record review and interview of facility staff it was determined the facility staff failed to ensure that Resident #3's representative was notified of a hospital transfer and the reason for the transfer in writing, and failed to provide a copy of the notice to the representative of the Office of the State Long-Term Care Ombudsman. This was evident for 1 of 13 residents reviewed. Resident #3 was affected by the deficient practice. The findings include: Medical record review on 4/10/19 through 4/12/19 and 4/15/19 through 4/16/19 revealed that Resident #3 has resided at the facility since 2008. The resident has a [DIAGNOSES REDACTED]. Medical record review revealed that on 9/6/19 Resident #3 was transferred to the hospital on an emergency petition due to spreading feces around his/her room, breaking a piece of furniture and taking the screen out of the window of his/her room and trying to get out of the window. Further review of the medical record and interview of the Nursing Home Administrator on 4/16/19 at 2:42 p.m. revealed that the facility staff failed to notify the resident's representative of the hospital transfer in and reason for the transfer in writing and failed to provide a copy of the notice to the representative of the Office of the State Long-Term Care Ombudsman.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on medical record review, interview of facility staff and observation it was determined the facility staff failed to initiate and implement interventions to monitor a resident with suspected heart failure and [MEDICAL CONDITION] (Resident #9); and failed to provide appropriate care to residents with urinary catheters (Resident #6, Resident #11 and Resident #13). This was evident for 4 of 13 sampled residents reviewed. The findings include: 1) Medical record review 4/10/19 through 4/12/19 and 4/15/19 through 4/16/19 revealed that Resident #9 had a [DIAGNOSES REDACTED]. Medical record review revealed that on 3/8/19 at 9:41 a.m. the nurse documented that Resident #9 was observed with shortness of breath and lethargy. The resident's pulse rate was 92 and respiratory rate was 24 (a normal respiratory rate is 12 to 20 breaths per minute). The nurse practitioner was notified at 9:50 a.m. Medical record review revealed that on 3/8/19 the resident was seen and examined by the nurse practitioner for follow-up management of heart failure, [MEDICAL CONDITION] and chronic [MEDICAL CONDITION] with [MEDICAL CONDITION]. The nurse practitioner documented that the resident was assessed with [REDACTED]. The nurse practitioner documented in the plan to continue oxygen and monitor oxygen saturations. The nurse practitioner ordered a chest x-ray, [MEDICATION NAME], a diuretic medication, 20 mg. intramuscularly daily x 4 days, [MEDICATION NAME] 40 mg. by mouth daily x 5 days, nebulizer treatments every 4 hours, an indwelling urinary catheter to maintain accurate input and output, and a stat (right away) complete blood count and comprehensive metabolic panel. The nurse practitioner further documented that the contingent plan would be to send the resident to the hospital for further evaluation if no improvement occurred. Medical record review revealed that there is no further documentation of a respiratory or cardiac assessment of the resident by nursing staff after 3/8/19 at 9:41 a.m. including monitoring of the resident's vital signs, oxygen saturation or intake and output. Additionally, nursing staff failed to document the administration of [MEDICATION NAME] or nebulizer treatments on 3/8/19. Staff #2, the nurse that cared for the resident on 3/8/19 on the 7:00 a.m. to 3:00 p.m. shift was interviewed on 4/11/19 at 4:15 p.m. It was determined that the nurse had failed to document administration of medications, documentation of assessment of the resident's condition and documentation of input and output for the resident. When Staff #2 was questioned about the reason for failing to document assessment, medication administration, or ongoing monitoring of the resident's condition, Staff #2 stated: I had orders and I was trying to catch up. I wasn't given an order to monitor. Interview of the nurse practitioner, Staff #3, on 4/12/19 at 10:40 a.m. revealed that on the morning of 3/8/19, she was called by nursing who advised her that the family was concerned about the resident's condition and felt the resident should go to the hospital. The nurse practitioner stated that prior to coming to the facility, she ordered a chest x-ray. The nurse practitioner stated that the resident was clinically stable when she examined the resident. She stated that the resident had a lot of fluid build up in the lower extremities. The nurse practitioner stated that she discussed the plan of care with the resident and the resident's family member. The nurse practitioner stated that all orders were in place for x-ray, laboratory work and medications and were discussed with the nurse. The nurse practitioner stated that [MEDICATION NAME] was given at the bedside and an indwelling urinary catheter was ordered to monitor the resident's intake and output. The nurse practitioner stated that the resident's intake and output and vital signs should have been monitored every shift and with any change in condition. Medical record review revealed that the next documented assessment of the resident was on 3/9/19. The nurse, Staff #4, documented that at 10:55 a.m. the physician was notified that the resident was having labored breathing. The resident's blood pressure was low, 71/44, the pulse rate was high, 101 beats per minute and the respiratory rate was high, 24 breaths per minute. Staff #3 documented that the resident's breath sounds were diminished bilaterally. The resident was subsequently sent to the emergency department via 911 on 3/9/19 at 11:15 a.m. Review of the hospital medical record, which was provided to the surveyor on 4/18/19, revealed that upon arrival at the hospital emergency department, the resident reported worsening shortness of breath for 3 days. The resident was intubated in the emergency department to assist with breathing. At 2:25 p.m. the resident went into [MEDICAL CONDITION] and was subsequently pronounced dead at 3:01 p.m. in the emergency department. The final [DIAGNOSES REDACTED]. 2) Medical record review on 4/15/19 and 4/16/19 revealed that Resident #6 has resided at the facility since (MONTH) of (YEAR). The resident has a [DIAGNOSES REDACTED]. Review of Resident #6's physician's orders [REDACTED]. Review of Resident #6's (MONTH) 2019, (MONTH) 2019, (MONTH) 2019 and (MONTH) 2019 treatment administration records revealed

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215020	A. BUILDING _____ B. WING _____	**04/16/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FORESTVILLE HEALTHCARE CENTER	**7420 MARLBORO PIKE FORESTVILLE, MD 20747**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) that the facility staff failed to document the residents urinary output every shift as ordered by the physician. The Unit Manager, Staff #4, was interviewed on 4/16/19 at 4:25 p.m. Staff #4 stated that staff should be recording urinary output for any resident with an indwelling urinary catheter. Staff #4 further stated that the staff were documenting their initials, but not documenting the amount of urinary output for Resident #6. Observation of Resident #6 on 4/16/19 at approximately 5:00 p.m. revealed that the resident's indwelling urinary catheter was not secured with a catheter stabilization device. A catheter stabilization device provides comfortable, secure and hygienic placement of the catheter away from areas of the body that could lead to bacteria contaminating the surface of the catheter. A stabilization device further prevents the catheter from becoming misplaced which can lead to trauma and obstruction of urinary flow. 3) Medical record review on 4/16/19 revealed that Resident #11 has a suprapubic urinary catheter care every shift, secure straps if applicable and documentation of urinary output every shift. Review of Resident #11's (MONTH) 2019 treatment administration record revealed that the facility staff failed to document the resident's urinary output every shift as ordered by the physician. After surveyor intervention on 4/16/19, the facility staff ensured there was an entry on the treatment administration record to record the resident's urinary output every shift. 4) Medical record review on 4/16/19 revealed that Resident #13 has a suprapubic urinary catheter. The resident has a physician's orders [REDACTED]. Review of Resident #13's (MONTH) 2019 treatment administration record revealed that the facility staff failed to document the resident's urinary output every shift as ordered by the physician. After surveyor intervention on 4/16/19, the facility staff ensured there was an entry on the treatment administration record to record the resident's urinary output every shift.
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on medical record review it was determined the facility staff failed to appropriately assess and treat pressure ulcers. This was evident for 2 of 13 residents reviewed. Resident #1 and Resident #7 were affected by the deficient practice. The findings include: Medical record review on 4/10/19 through 4/12/19 and 4/15/19 through 4/16/19 revealed that Resident #1 was admitted to the facility on [DATE]. Medical record review revealed that on 7/16/19 the nurse completed the Admission Observation Tool. Review of the Admission Observation Tool revealed that the nurse documented that the resident had 2 skin areas of concern which were identified as the left buttock and the sacrum. Medical record review revealed that on 7/16/19 the nurse documented the following entry in the skilled documentation: . WOUND OBSERVATION: Existing Wound. Sacrum - length 2 cm, width 7cm, left inner buttocks wound L (length) 3 cm. width 3 cm Other (specify) - . (W)wound on sa(c)rum was not with bright red moderate bleeding. Left inner buttock wound noted with slough on the surrounding area of the wound and redness on the base . Medical record review revealed that on 7/17/18 the nurse completed a skin grid for a community acquired pressure ulcer of the sacrum. The nurse documented that the resident's sacral pressure ulcer measured 4 cm x 7 cm x 0.1 cm and was a stage 2 pressure ulcer. Granulation tissue was present, the wound bed was pink and there was a scant amount of exudate. There is no documentation of assessment of the left inner buttock wound identified on 7/16/19. Medical record review revealed that on 7/24/18 the nurse completed a skin grid for a community acquired pressure ulcer of the sacrum. The nurse documented that the resident's sacral pressure ulcer measured 4 cm x 7 cm x 0.1 cm and was a stage 2 pressure ulcer. Granulation tissue was present, the wound bed was pink and there was a scant amount of exudate. There is no documentation of assessment of the left inner buttock wound identified on 7/16/19. Medical record review revealed that on 7/27/18 the nurse completed a skin grid for a house acquired pressure ulcer of the left buttock. The nurse documented that the left buttock pressure ulcer was a new area reported. The left buttock pressure ulcer measured 3 cm x 2.5 cm x unable to determine and was a stage 3 pressure ulcer. Granulation tissue and slough (devitalized tissue) were present. The wound bed was pink and yellow and there was a small amount of exudate. Interview of the wound care nurse on 4/15/19 at 3:04 p.m., Staff #1, revealed that she recalled that the resident's left buttock wound was like scar tissue and was not an open area on 7/17/19. However, Staff #1 failed to document an assessment of the left buttock area, even though it was a documented as a skin concern by the nurse on 7/16/18. Further interview of Staff #1 revealed that a nurse contacted Staff #1 on 7/27/19 and reported that the resident's left buttock wound was an open area. Although the resident's left buttock was an area of concern on 7/16/19, there is no documentation of assessment or interventions to treat the area of concern. 2) Medical record review on 4/10/19 through 4/12/19 and 4/15/19 through 4/16/19 revealed that Resident #7 had resided at the facility since 2012. Medical record review revealed that on 1/4/19 the nurse, Staff #2, documented on the skin grid that the geriatric nursing assistant notified the nurse that the resident had a left buttock skin tear. The nurse, Staff #2 documented that the left buttock skin tear measured 5 cm. x 3 cm. x 0.1 cm., was red, moist grainy, optimal granulation and no exudate was present. The nurse, Staff #2, further documented that she dressed the skin tear with gauze and wound honey and covered the resident up. Medical record review revealed that there is no documented evidence that the nurse, Staff #2, notified the physician of the resident's left buttock skin tear or obtained a treatment order for the resident's left buttock skin tear. Between 1/4/19 through 1/11/19, 1 week, there is no documentation of assessment and/or treatment to the resident's left buttock skin tear.Medical record review revealed that on 1/11/19, the nurse documented in the Concurrent Review that the resident was assessed with [REDACTED]. x 8 cm. which was black (necrotic) with a small amount of serous drainage. The physician was notified and ordered a treatment to the left buttock pressure ulcer which was initiated on 1/12/19. Interview of the wound care nurse, Staff #1, on 4/15/19 at 3:04 p.m. revealed that she was not in the facility the week of 1/4/19. Staff #1 confirmed that on 1/4/19 there is no documented evidence of assessment of the wound, no evidence that the physician was notified or that a treatment order had been given and/or transcribed 1/4/19 through 1/11/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215020	A. BUILDING _____ B. WING _____	07/24/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FORESTVILLE HEALTHCARE CENTER	7420 MARLBORO PIKE FORESTVILLE, MD 20747

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 0573 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Let each resident or the resident's legal representative access or purchase copies of all the resident's records.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on interview of facility staff it was determined the facility failed to provide Resident #2's representative with a copy of the resident's medical record in a timely manner. This was evident for 1 of 3 sampled residents selected for review.The findings include: Resident #2 was admitted to the facility on [DATE] for rehabilitation. The resident expired at the facility on [DATE]. On [DATE] the Office of Health Care Quality received a complaint from Resident #2's representative alleging that an authorization form for the release of Resident #2's medical records was submitted to the facility on [DATE]. On [DATE] the complainant alleged that he/she spoke with Staff #1 regarding the medical record request and was told the medical record would be sent. The complainant/resident's representative alleged that after multiple messages were left for Staff #2, on [DATE], Staff #2 informed the complainant/resident's representative that the medical record request would need to be referred to the facility's legal team. On [DATE] the Nursing Home Administrator advised the surveyor that a request for Resident #2's medical record was made in (MONTH) (YEAR), and the medical records were sent to the resident's representative on [DATE].
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on medical record review it was determined the facility staff failed to document an assessment of a pressure sore and failed to promptly initiate the treatment of [REDACTED].#1. This was evident for 1 of 3 sampled residents selected for review. The findings include: Resident #1 was readmitted to the facility on [DATE] after a hospitalization . The resident's medical record was reviewed on (MONTH) 20, (YEAR), (MONTH) 23, (YEAR) and (MONTH) 24, (YEAR). Review of the Skin Grid Pressure, an assessment tool for pressure sores utilized by the facility, dated 12/31/17, revealed that the resident had a stage 3 sacral pressure sore that measured 1 cm x 0.5 cm x 0.3 cm with pink granulation tissue and a small amount of exudate that was present on readmission to the facility on [DATE]. However, there was not a documented assessment of the pressure sore on 12/24/17. Review of the Treatment Administration Record revealed that a treatment to the sacral pressure sore was not initiated until 1/3/18, 9 days after the resident was readmitted to the facility.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on medical record review it was determined the facility staff failed to ensure that Resident #1, who was dependent on a gastrostomy tube for nutrition and hydration, received adequate water flushes to prevent dehydration. This was evident in 1 of 3 sampled residents selected for review. The findings include: Resident #3 was admitted to the facility in (MONTH) (YEAR). The resident had a gastrostomy tube for the administration of nutrition and hydration. A gastrostomy tube is a flexible tube, surgically inserted through the abdomen, that delivers nutrition and hydration directly to the stomach. The resident's medical record was reviewed on (MONTH) 20, (YEAR), (MONTH) 23, (YEAR) and (MONTH) 24, (YEAR). Medical record review revealed that the resident was readmitted to the facility on [DATE] after a hospitalization . Review of the hospital progress notes, dated 12/22/17, revealed that the resident's tube feeding should be slowly titrated up to a goal rate of 65 ml. per hour. Medical record review revealed that the resident's admission tube feeding orders were Glucerna 1.5 via gastrostomy tube at 50 ml. per hour x 18 hours which provided 1,350 calories and water flushes of 250 ml. every 6 hours. There was not a physician's orders [REDACTED]. per hour. Medical record review revealed that on 12/30/17 the Dietitian completed the resident's nutritional assessment. Based on the resident's weight of 156.6 pounds, the Dietitian recommended Glucerna 1.5 65 ml. per hour x 18 hours and water flushes of 220 ml. of water every 4 hours. A physician's orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. of water every 4 hours. Medical record review revealed that the resident was readmitted to the facility on [DATE] after a hospitalization . Medical record review revealed that the resident's weight on 3/7/18 was 148.2 pounds (67 kg.). The resident's admission tube feeding orders were Glucerna 1.2 60 ml. per hour x 11 hours and water flushes of 150 ml. every 6 hours. Based on the resident's weight of 148.2 pounds (67 kg.), the resident's fluid requirement was 2,010 ml. of water per day (30 ml/kg.). The tube feeding order provided the resident with a total of 1,131 ml. of water per day which was significantly less than the resident's water requirement based on the resident's weight of 148.2 pounds (67 kg.). Medical record review revealed that on 3/12/18 the resident's weight was 144.8 pounds. The resident had lost 3.4 pounds (2.3% of body weight) over 5 days, which is suggestive of fluid loss. Additionally, laboratory blood work on 3/12/18 revealed that the resident's BUN/creatinine ratio was 41.1. The normal range is 8.0 - 25.0. An elevated BUN/creatinine ratio is suggestive of dehydration. Medical record review revealed that on 3/12/18 the Dietitian completed the resident's nutritional assessment. Based on the assessment, the Dietitian determined that the resident's tube feeding was not meeting the resident's nutritional or hydration needs. The resident's tube feeding was increased to Glucerna 1.5 at 65 ml. per hour x 18 hours and water flushes were increased to 75 ml. per hour x 18 hours which provided the resident with a total of 2,238 ml. of water per day. From 3/7/18 through 3/12 18 the resident had a water deficit of approximately 879 ml. per day.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.**

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215020	A. BUILDING _____ B. WING _____	**07/24/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FORESTVILLE HEALTHCARE CENTER	**7420 MARLBORO PIKE FORESTVILLE, MD 20747**

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 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on medical record review it was determined the facility staff failed to promptly respond to the consultant pharmacist's recommendations related to drug irregularities for Resident #1. This was evident for 1 of 3 sampled residents selected for review. The findings include: Resident #1 was readmitted to the facility on [DATE] after a hospitalization . The resident's medical record was reviewed on (MONTH) 20, (YEAR), (MONTH) 23, (YEAR) and (MONTH) 24, (YEAR). Medical record review revealed that on 1/24/18 the consultant pharmacist reviewed the resident's medication regimen. The following recommendations were made to the physician: 1. This [AGE] year old resident has an order for [REDACTED]. the extended-release product, [MEDICATION NAME] ER ([MEDICATION NAME] XL). Only the extended-release product has been approved for the treatment of [REDACTED]. The immediate-release [MEDICATION NAME] in elderly for the treatment of [REDACTED]. (1) Given the increased risk to this resident, please discontinue the immediate-release [MEDICATION NAME] 10mg. capsule. (2) As this resident has a [DEVICE], and the extended-release [MEDICATION NAME] ER tablet can NOT be crushed, an alternative calcium channel blocker, such as [MEDICATION NAME], is recommended. The physician did not address the pharmacist's recommendation until 2/18/18 at which time the physician agreed with the recommendation, however, failed to discontinue the medication. On 2/22/18 the consultant pharmacist documented that the recommendation was resubmitted to the physician. However, review of the Medication Administration Record [REDACTED]., 3 capsules every 12 hours through 3/2/18, at which time the resident was discharged to the hospital. 2. Resident has an order for [REDACTED]. To avoid confusion re: 'remove per schedule', please clarify order to include exactly when the [MEDICATION NAME] is to be removed. The physician did not address the pharmacist's recommendation until 2/21/18 at which time the physician agreed with the recommendation. However, review of the (MONTH) (YEAR) and (MONTH) (YEAR) MAR indicated [REDACTED].M., but was not being removed at bedtime through 3/2/18, at which time the resident was discharged to the hospital. 3. This [AGE] year old resident has an order for [REDACTED].g. dyskinesias, hallucinations, drowsiness, tremor, and restlessness). The risk for IRREVERSIBLE tardive dyskinesias is significantly increased when used in older individuals. Please consider discontinuing [MEDICATION NAME]. Alternative therapy, such a proton pump inhibitor - which is actually the preferential treatment for [REDACTED]. The physician did not address the pharmacist's recommendation until 2/21/18 at which time the physician agreed with the recommendation to discontinue the medication. However, review of the MAR indicated [REDACTED].
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on medical record review it was determined the facility staff failed to ensure that Resident #1's drug regimen was free from unnecessary medications. This was evident for 1 of 3 sampled resident selected for review. The findings include: Based on medical record review it was determined the facility staff failed to promptly respond to the consultant pharmacist's recommendations related to drug irregularities for Resident #1. This was evident for 1 of 3 sampled residents selected for review. The findings include: Resident #1 was readmitted to the facility on [DATE] after a hospitalization . The resident's medical record was reviewed on (MONTH) 20, (YEAR), (MONTH) 23, (YEAR) and (MONTH) 24, (YEAR). Medical record review revealed that on 1/24/18 the consultant pharmacist reviewed the resident's medication regimen. The following recommendations were made to the physician: 1. This [AGE] year old resident has an order for [REDACTED]. the extended-release product, [MEDICATION NAME] ER ([MEDICATION NAME] XL). Only the extended-release product has been approved for the treatment of [REDACTED]. The immediate-release [MEDICATION NAME] in elderly for the treatment of [REDACTED]. (1) Given the increased risk to this resident, please discontinue the immediate-release [MEDICATION NAME] 10mg. capsule. (2) As this resident has a [DEVICE], and the extended-release [MEDICATION NAME] ER tablet can NOT be crushed, an alternative calcium channel blocker, such as [MEDICATION NAME], is recommended. The physician did not address the pharmacist's recommendation until 2/18/18 at which time the physician agreed with the recommendation, however, failed to discontinue the medication. On 2/22/18 the consultant pharmacist documented that the recommendation was resubmitted to the physician. However, review of the Medication Administration Record [REDACTED]., 3 capsules every 12 hours through 3/2/18, at which time the resident was discharged to the hospital. 2. Resident has an order for [REDACTED]. To avoid confusion re: 'remove per schedule', please clarify order to include exactly when the [MEDICATION NAME] is to be removed. The physician did not address the pharmacist's recommendation until 2/21/18 at which time the physician agreed with the recommendation. However, review of the (MONTH) (YEAR) and (MONTH) (YEAR) MAR indicated [REDACTED].M., but was not being removed at bedtime through 3/2/18, at which time the resident was discharged to the hospital. 3. This [AGE] year old resident has an order for [REDACTED].g. dyskinesias, hallucinations, drowsiness, tremor, and restlessness). The risk for IRREVERSIBLE tardive dyskinesias is significantly increased when used in older individuals. Please consider discontinuing [MEDICATION NAME]. Alternative therapy, such a proton pump inhibitor - which is actually the preferential treatment for [REDACTED]. The physician did not address the pharmacist's recommendation until 2/21/18 at which time the physician agreed with the recommendation to discontinue the medication. However, review of the MAR indicated [REDACTED].

MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGI EN ;
OFFICE OF HEALT H CARE QUALITY

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Patricia Tomsko Nay, M.D
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Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines

£ib MARYLAND
Department of Health
Larry Hogan, Governor - Boyd K. Rutherford, Lt. Governor - Robert R. Neall, Secretary

March 7, 2018

Attn: C;il;mthl.i Green, Acfmlnist rJ to r
f"orestvill c He.11th :in d Rch;,blli1ationCenter
7iS20 Matlboro Pike
Forc tvillc, MO 20747

Oc3r M s. Green:

This le tter is to acknowle dge 1cceipt of Jn J pplitJtlon *to* opc r.nc forcstvlll c Health :ind Rc habll itJ tio n Center

The cnctoscd license will be in cffoct until April 19, 2020, unless revoked. It is vo ur authority *to* maint.iln a comprehensi vecare facility withalicCMCd c.1pacity of 162 beds under the provision of COMAR 10 .07.02.

This license Is to be displayed in a conspicuous place. at *or* ne.irthe entrance of your facility. plainly visible :.nd casity rc;id bv the public,

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Room and bed brcal(down:

CATEGORY	LOCATION	TOTAL
Comp,c hcnsivc CareF'acliitv	FirstFloor	
	Ouple• Rooms: 113, l M, 216.117, 119. 120,1,25 127, 128, 130, 131, 132, 152.154, 155, IS?, 15S	34beds
	Triph Rooms: 102. 103. IOS,106, 108, 109,135, 136, 138.139, 141, J.12, M6, 1'17,149, 150	*48* beds
	Total First Floor	82beds
	Second Floor	
	Single Roo ms: 2S2	01 beds
	Duple• Rooms: 213. 214,216,217,219, 220, 224, 225.22?. 228. 230,231,246,2S4, 2SS, 257. 2SS	34 beds
	Triple Roo ms: 202, 203. 20S 206, 208. 209, 235, 236. 238, 239. 241.242, 24? 249, 250	45 beds
	Total Second floor	SObed s
	Ovcr.1II Total	162beds

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APPLICANT INFORMATION E-mail [redacted]

Name of Facility Marlboro Leasing Co, LLC dba Forestville Health & Rehabilitation Center Telephone No 301-736-0240

Location 7420 Marlboro Pike
(Street)

Forestville Prince Georges 20747
(City) (County) (Zip)

TYPE OF BUSINESS ORGANIZATION
☐ Individual ☐ Partnership ☐ Corporation ☐ Association ☑ Other: LLC

☐ 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) Marlboro Leasing Co, LLC 7420 Marlboro Pike, Forestville MD 20747
Lessor Name(s) and Address(es) Maryland NH Asset, LLC 4700 Ashwood Dr, Suite 200, Cincinnati, OH 45
Expiration Date of Lease multi year 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. Names and addresses of their board members shall be submitted.

Administrator Calanthia Green Administrator License No: R1787

LONG TERM CARE FACILITY TYPE
☑ Nursing Home ☐ Comprehensive Care Facility
☐ Hospital Extended Care Facility
Number of Beds:
☑ Room & Bed attached Exhibit A

☐ Does facility operate a special care unit?
☐ YES: Type
Number of Beds
☑ NO

The 2-year license fee of $ N/A (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, Calanthia Green, ...

... are 18 years of age or older and of reputable and responsible character ... subject to the provisions of Health-General Article, Title 19, ... Annotated Code of Maryland ... there under by the Secretary of Health and Mental Hygiene.

1. Signature of Applicant Calanthia Green Title Administrator

2. Signature of Applicant Title

Subscribed to before me this 27 day of February, 2018 a Notary Public for the State of Maryland

My Commission expires 6/3/2018
Notary Public

KIMBERLY FREEMAN NOTARY PUBLIC ANNE ARUNDEL COUNTY, MD My Commission Expires 06-03-2018

SEND COMPLETED APPLICATION TO:

FOR OFFICE USE ONLY

Initial	Date:	Amt PD:
Renewal	Ck#:	Coord Name:
Change of Ownership	Registration #:	License#:

DHMH 125A – Revised 3/16/2010

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Calanthl.:,Green. Admini s1r.:i1or
Forcst vlllc He.11th and Rehabllit,1tlon Center
J:muary 30, 2018

The room and bed breakdown Is 3S follows :

CATEGORY	1,0S AIION	TOTAL
Comprchcns e Core J:Jclllty	J:lrst Floor	
	Duplex Rooms: 113, 114, llG, 117, 119, 120, 12S. 127.128, 130, 131. 132. 152.154.155, 157,158	34 beds
	Triple Rooms: 102, 103, 10s. 106. 108, 109. B S, 136, 138, 139. l •H , 142, 146, 147.,119 150	-18 beds
	TotJI First Floor	82 btds
	Second Floor	
	Sinstc Room 2S2	1bed
	Duplex-Rooms: 213, 2M, 216,217,219, 220. 224,225,227,228. 230.231,246, 2s.:.2ss. 2S7. 2SS	34beds
	Triple Rooms: 202, 203, 20S, 206. 208, 209,235.236. 238. 239, 241.242.247,249,250	45 beds
	Total Second Fl oor	**80bods**
	Ovcr:.11 To t a-I	162 bods

SE CTIONn- LONG TF.R".1 = PROVIOl!R AP?I. ICAno:-.

P R/lsCIPAI. PHYSICIANAORJib'ME:-<T

Name of Facility: Forestville Health & Rehab **License #:** 116017

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3. I will provide medical direction and coordination of the facility's medical care.

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6. I will be responsible for the surveillance of employee's health program.

Principal Physician (signature) — Date: 1/30/2018

Principal Physician Information (please type of print)

Name: Harold	B.	Bob
(First)	(Middle)	(Last)

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DHMH 125G– Revised 3/16/2010

SECTION 9 - LONG TERM CARE PROVIDER ,\ PPLICATION

RELIEI' PHYS IC,lI N AGREEMENT

Name of Facility: Forestville Health & Rehab **License #:** 16017

NOTE: *Th, Stair Dtpartmc,rtof 11-tulth R'tula1Ia11.1 rtquirt that taclr Comprdtc,ufrot Cur< Fadllty J0.0 7,01 ammttJot aph)' ldan IDS(l \'t as a Principal Pliyll,Ian ,md a qualifltd 1(1/t/I()co,w ptrlodsh 'ht n h is or Jiu Stt \'lca OU not an1llablt.*

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3. *I will provide medical direction and coordination of the facility's medical care.*

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Relief Physician (Signature) Date 1-21-18

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SECTION C-LONG TERM CARE PROVIDER ArrLIC/\TION

DIRECTOR OF NURSING /\GREEME1"T

Name of Facility: Forestville Health & Rehab **License #:** 16017

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Namr

A. Htcbtt'rtd Nunt', registry numbc, 2 /39bLQ

B. Licensed Practical Nurse, Board of Nursing registry number________________

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(l)l, c tor of Nini11;;)

Calacthia Green

Facility Administrator (signature)

1-30-18

Date of Agreement

STATE OF MAIW I.AS O

DHMH

Maryland Dcpanmcnl of Heulth and Menial Hygiene
Office of He:ilth C:irc Quality
Spring Grove Center • Bland Bryant Building
55 \Vadc Avenue• Calonsvillc. M:irylnnd 2122S-4663
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MEOICAL CA.RE PROGRAM • .P.ROVID liR AP'PLICA T!·ON

MPORTANT: PLEASE READ ATTACHED INSTRUCTIONS BEFORE COMPLETING APPLICATION

1) APPL!IC.A:TION. TYPE:

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· Pr ·ider/Change

'rovider Number Medicaid [redacted]

am applying as a.... Please cl OM.:

Requested Enrollment Begin rv/A

❑ Group

❑ Individual/Pract =S¢!Q ?'rtl(:l! tw' H ii' r of Gtr.lJp (lease circle type)

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2) PROVJm :.:R.I N.FORMATJOt

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Group/Facility/Business/Agency Name			Fiscal Year End Date
Marlboro Leasing Co.,LLC dba Forestville Health + Rehabilitation Center			12/31
Physician/Practitioner Last Name	First Name		Title
Contact Person Name and Telephone Number		E-mail/Website Address	
Charles R. Stoltz 513-530-1613		cstoltz2@chs-corp.com	
Primary Practice Address		Suite Number	Handicap Access
7420 Marlboro Pike			
City	State	Zip Code	
Forestville	MD	0747	
Telephone Number	u lumber	*County Code	*Provider Type Code
301-736-0240	301-736-1129	16	
Employer Identification Number	Name of EIN Owner		
[redacted]	Marlboro Leasing Co., LLC		

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Name	Medicare Number
Forestville Health + Rehabilitation Center	[redacted]

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Address

City | S,Uil:ll

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

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Telephone Number	Coun COdi,	License Number ______ Expiration Date______

Practice Address #2	Suite Number	Handicap Access

City	State	Zip Code

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4) PRACTCEUIFORMATION

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* Type of Practice	*HMO Type Category
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S)SPECIALITY INFORMATION

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6) SPECIALTY VERIFICATION

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7) GROUP MEMBERSHIP INFORMATION

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SECTION O• MEDICAL CAAEPROOAAII • PROVIDER APPLICATION

ll)AUTHORIZATION

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Date 2/2/18

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

Charles R. Stoltz

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

N/A

Signature of Owner (in the case of a Pharmacy)

Please rC-:urn eomp\:l:od appllc3tlon lo: Syst.ems ond Opefi'.f.ions Ad trotion
Prci tle,t EnorUmcn1
P.O. Box 17030
8.Jltimore.MD21203

PRACITTIONER Nl

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lABORATORY INFORMATIONrll l'<

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Your Fiscal Year End Date:

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SF.CT I ON D

PROVIDER OWNERSHIP AND CONTROL DISCLOSURE FORM

Marlboro Leasing Co., LLC dba Forestville Health Rehabilitation Center

Name of your Medical Service of Supply provider Ownership (as contained on your application

(i\ppk;attco1 .at Provider , orQtOuP'lor p, ..oro1",

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-S1e,+ , ,, r e.-;cd,(... Cbe cts, *R.* S1-.,l-t2

Ronald S. Wilheim

2. b *ti* P ll rtl'lef

3 has a direct or indirect ownership interest* of 5% or more

amG,PE Leasing Co.,LLC, Stephen L. Posedale

Charles R. Stdtz, Ronald S. Wilheim, Isaac Posedale

4. has a combination of direct and indirect ownership interests equal to 5% or more in the Provider

Same as #3

5 b .in o.-nor (in whO!e ot In p:irt) or on11"1c ro $ o! 5 % o r mo«t in .i.nymort9,,po,deedol trust. *n«o,*o, o:ticr obliga!lOn $00J!OC,(in "' hOlo*or* ii'\p:in) by *the* Pr0'1-,\dr;,r or its PfOPOl1Y ot a».0U.it 1n:i:ln,:e cs! Bl SO:tst $% ol thO va!uoof trioproPQrty or ouo ts of ll'lO *Pt t*

Omega Healthcare Investors, Inc

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all above re: Resident Care Consulting Co LLC

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See attached List Exhibit B

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Parent + child

S EC rl ON D

PROVIDER OWNERSHIP AND CONTROL DISCLOSURE FORM

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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.

Date: 2/2/18

AUTHORIZED SIGNATURE

POSITION

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SECTION E - STATE AFFIDAVIT

Wlu)c,•c r lcnowin:md willfully m:,kc.1or C!l1Uf$ 10 b('111::uk a fobt-Jl:tl cmcnl or **representation on this statement may be prosecuted under applicable State laws. In** :addIlion , km) \'\ inl! und wlllfoll)' falti n to fully:ind :1Cc' ur .tlC'l y d i>d, O '-" lltt information **requested may result in denial of a request to become licensed or, where the entity is already license, a revocation of that license.**

I certify that the administrative and procedural requirements contained in COMAR 10.07.02 (Regulations governing Comprehensive Care Facilities and Extended Care Facilities) in the areas of written administrative and resident care policies, By-laws and olhCr o r,.:inirntiunl1Idoc11111on 1.atnn, wriucn :asrtt nu:nb, wilh oul:slth• r 4)11r<('$/«>lu ulc:111l . co111111ill t:'t' m« li ns:s. $la ff (IU:tllllk :atfoo s :and "' rillc n dC'\ c lup 111c 11t 1trOj!r";111, 1 uch :Ii **inservices, equipment maintenance and disaster preparedness have not been substantively altered, revised, or modified, since the previous survey, or if they have, I have notified the** *Offitt* orHt:illhC:trC'Q u:11i1y.In,,·rllinc, bcrorc-lhc cff('CII\'(' d:all' or lhc ch:ins:c, Jrurl hH certify 1hat I will notify lhc Office or llf.:'all h Ci:ircQ ua lity if the rt' :arc:any fu1urc ··sub.,1111111\c i:11ani:<"$ in focllily man:ii:r nu:111 and OtH:r:itlon. .. ias th •0 1ml in the hu lruc tions **for completion of the Federal affidavit, that significantly affect policies and procedures and** lfu•t notkc will *bt* s:h•cn In \\Tilins: bcfon· lhl"d fr t th·t d :alc or l h r-cb:in:,:C'.

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Forestville Health & Rehabilitation Center

Signature of Authorized Official	Tille	Date
	CFO	2-16-18

SECT[ON F - \VORK · RS' COMPENSATJON LA\V Q ESl lONA[RE

Name of Facility

Forestville Health & Rehabilitation Center
(Please type or print)

\ddress of Facility

7420 Marlboro Pike, Forestville, MD 20747
(Please type or print)

Do you have Workers' Compensation Insurance for your employ(
(Check One) ☑ YES ☐ NO

If you have answered **YES** above; please provide the following information:

Policy Number: [redacted]

Binder Number: N/A

Insurance Company: PM Indemnity Company

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2/16/18
Date

SECTIO NG - CERTIFICATE OF COMl' LIANCE /\PPLICATION

INST RUCT IO N S HEET

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Line # 7 Sign and Date (If partnership, All partners must sign)

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SECTION G - CERTIFICATE OF COMPLIANCE APPLICATION

Licensing Agency's Stamp

APPLICATION FOR CERTIFICATE OF COMPLIANCE

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

3. Business Address (P. O. Box Not Acceptable)

4. Mailing Address

Zip Code

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

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.

SECTION G - CERT IFICATE0 1' COMPLIANCE APPLICATION

Date Stamp – WCC Use Only

WORKERS' COMPENSATION COMMISSION
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EXCLUSION FORM

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FORM C-1KR (Rev. 12/01/06)

SECT ION I: ADVERSE ACI"IONSICONV JCT IONS

·11lis section captures infonmuion on odvcrsc 1t:s:1 actions. such 3S convictions, exclusions, n: \'oc:uions. ond suspensions. ,\ II app1ic.nblc ndv rse legal:ictions must be reported. n:g:udlcss of whether anv n:cords were c uni;:cd o r anv oi, :1ls arc din .

ADVERSE ACTIONS THAT MUST BE REPORTED

Com·ic1ions

I. 11ic provider, supplier. or:my O\\I U;r of the provider or supplfor ,w:s . wit hin 1h c lai.;t 10 yen.rs pn-.cedins cnrolllm: nt or rcvnlid:11io n Qfe nrollme,nt convicted of:&: 1cdc r:il or State rctony 0 0 11.scthat CMS hasdctcm1incd to bedc1rimcn1nl10 the bcs1 intcn:sts of the progmm and its beneficiaries. Om: nscsinclude:

Fel ony cri1m:s usainst persons nnd 01hcr similur crimes for" •hich the individual \\':15 convicted. including guilty picas :md :.1J j utlic:i11:d prc -1riul Ji versions: lin:mci:11crimes. such as cx1o r1ion. e mbezzlement. income t 1xcv:i.,,jon. insurance tinud and other si mifar cri mes for which1hc individu:11w:1s convic1ed, includios guilty picas 1.1nd :idj udicoled prc-tri:il diversions; :my felony th11pl:aceJ the Medicaid program or its bcnclici:.uics at inum di:ttc risk (such *as* n malpr.tcticc suit1ha1 result,;in a convic1ion of criminal neglect or miscondui.:t): nnJ *:my* fd oni.:s th:11 wo uld result in n m:111d:ttol) cxd us ion under Scction 1128(:i) of the Ai.:t.

2. 1\ny misdemeanorc.onviction, under=1cdem l of S1111c la w. rd1111:'t1to:(n) the ddi\"Cr')' or n n item orservice under Medic-art: or a State health care progrnrn.or (b) tlu.:nbusc or neglect of n p:ilicnt in corm.:ctions with thedcli\'CC)' of n hc:1hh c:10: item o r Scf' •ice.
3. Any mi.sdcmc:i.nor conviction, under Federi.i ofS1ute lt1w. related 10thcll. rrnud. cmbc12k mcn1, bn:nch of fiduciary duty.or olhcr rimmcinl misconduct in co1111.:c1ion wi1hchc dcli\'Cl)' of 3 hcollh core it.:mor service.
4. Any misdemeanor conviction. under Fcdcml of Stt1tc law. rdmed to the interference wi1h or ob:;tnaction of any invcs1ii;:nion into:mycriminal onCnsc dcsc,ibcd in 42 C.F.R.Section 1001.101 or 100 1.201.
5. ,\ny misdemeano r convictio n, under: rcdenl l of St:itc law. rcl:1cd to the unl:1wful rnnnufoc1un:, dis1ribu1ion, prescription, or dispensing of u con1rollcd subs tnncc.

Exd usions. Revoca tions or Sus1 nslons

I. Any rcvoc:ttion or sus pcn::.ion ofo lice nse 10 provide hc-:,h h core by:my Stmc licensing nu1hority. This includes the SuJTcndcr or s uch license while n fomml disciplin:try proceeding was pending before u S11:tc licensing ou1hori1y.
2. ,\ ny T\:VOC:'.llion of suspension of :iccrcditntion.
3. 1\ny suspension or excl usion from particip:uion in. or :my s:111c1ion imposed by. n f cdcml or S1:11e h.::1hh c-:m: program, or any dcb:im1cn1 from p:1rticip11ion in nny Federal E;ccutivc Or.mch procuf\:mi:n1o r non-ptocurerncnl progrnm.

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5. Any Mcdic;1n: rcvoc:11io n of any kdic:m: billing number.

SECTION I: ADVERSE ACTIONS/CONVICTIONS (rnn11•••"l

ADVERSE LEGAL HISTORY

I. Hts your org:mil:11ion. under any current or fom1cr nnmc or busincs$$ identity, c\•cr hns nn ad.,:crsc nction lish:d on ·utc l ofScc1ion I im scd am1ns1it?

☐ YES – Continue Below NO

2. If yes. n:port coch nd,:crsc action. when it occurred, 1hc Fede ral or Sm1c agency or the court/ndministr:ui;c body that imposedthe:1ction, :mJ the n:s.olution. if any. ,\u:1clo copy of the ndw:rsc nclion documcnrnlion ond n".So lution.

Adverse Action		T:akC'n U.y	Rt'$U1l11lon

SECTJON J:- · 11AI HOME OFFI E IJ 1•0 RMATIO

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For more information on chain organizations, se 42 C.F.R. 421.404.

CHECK HE.RE ☐ If SECTION J DOES NOi APPLY ,\ NU SKIP TH[S SECT[ON

A. TI·PE OF ,ACTION 'f UIS PROVJDER JS REPORTING

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☐ Provider has changed form one chain to another		·ompk te Section J in fidl to idcnicify thi:111 \ dmin home of11lc-,c.
☑ The name of provider's chain home office is changing *(all other information remains the same).*	2005	omplete Section J-C.

n. CHAIN HO n: OFFICE ADMINISTRATOR INFORMATION

Name of Home Office: Healthcare Facility Management LLC	First Name: Charles	Middle Name: R	Last Name: Stoltz	Jr., Sr., etc.
Title of Home Office Administrator: CFO		Social Security Number: [redacted]	Date of Birth *(mm/dd/yyyy)*: [redacted]	

SECTIO • J: CHAIN HOME OFF.I CE I FORMATION ri l'ltr,,.. I

C. CHAIN HOME OFFICE INFORMATION

Name of Home Office as Reported to the Internal Revenue Service
Health Care Facility Management, LLC

Home Office Business Street Address Line 1 (Street Name and Number)
4700 Ashwood Dr

Home Office Business Street Address Line 2 (Suite, Room, etc.)
Suite 200

City/Town	State	ZIP
Cincinnati	OH	45224

Telephone Number	Fax Number (if applicable)	E-mail Address (if applicable)
513-489-7100	513-530-1359	

Home Office Tax Identification Number	Home Office Cost Report Year-End Date
[redacted]	12/31

Home Office Fee-For-Service Contractor	Home Office Chain Number
	36-H163

D. TYPE OF BUSINESS STRUCTURE OF THE CHAIN HOME OFFICE

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E. PROVIDER'S AFFILIATION TO THE CHAIN HOME OFFICE

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Revised 3/16/2010

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Nort .1:,t lc.aslng:Co,. llC	M.1ple Wood He.althu rc Ce-nt e-r	724 NE 79;h rerr .i ce	ICa n s .1:s City	MO	64118 ·JS64	Sl C,-436•8940	816-436-9289	SNf	265366
Howu d t.t u ing Co•. UC	M,1:rlcy tied:He,dth & Rehl bititl tloncc nte-r	7575 E. How.1rd **Rold**	Glen Burnie	MO	21060--8312	411)..768-8 200	410-76S Z9'S4	INF	211138
Nor\hw t1t SNr,UC	NOC'lhwtit Hc.ah h<.at(' Cen ter	.\601 P.aUM.1:0 Ro:,cd	8.ll!imore	MO	21215·6414	410-664·SSS1	410-664•106!	SNf	21S346
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brvbl e.11in&C,o. llC	Pt-bblt Cttt lt Hta.!Ux .11r t-cen1er	670 Jar,..ls Rd	Akron	OH	4'319-2538	H0-645-0200	330-641-0316	SNf	36S727
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St. ph lc-:a"ng Co• llC	Rollins mns Ht .aHhu, c-Cent e r	3625 lnt Joost ph Ro:ad	N ew Alb.l nv	ITI	4 71 5 0--9'14S	812-9.\8-0670	312•943 222	SNF	!S S4a8
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MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF ALTH CARE QUALITI'

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 W E AVENUE
CATONSVILLE, MARYLAND 21228

icens **No. 16017**

Issued to: Forestville Health & Rehabilitation Center
7420 MJiboro Pike
Forestville, MD 20747

Type of Facility and Number-of Beds:
Coμiprehe,g,sive Care Facility - 152 Beds

Date Issued: April 19, 2014

This,:license has been granted to: Marlboro Leasing Co, L;LC

Authority to <?PC te in this State is granted to the above entity pursuant to The HealthaGeneral Article,. Title 19 Section 318, Annotated Code of Maryland, 1982 Edition, and subsequent supplements and is subject to any and all statutory provisions, including all applicable rules and regulations promulgated there under.

':Qlis dOCUl'JICll! is not transferable.

Expiration Date: A pril19, 2016

Director

Falsification of a li ense shaU subject the perpetrator to criminal prosecution and the imposition of civil fines.

STATE OF MARYLAND
DHMH

Mary ' n ' ' epar 1nen t of Health and Menta l Hygie ne
Off ice of Hea lth Ca re Qual it y
S pr ing G ro ve Center • Bla nd Bryant Bui ld i ng
55 Wade Aven ue • C a to ns vi Ile, Ma ryla nd 2 1 22 8-4 66 3

Mani n 0' Ma lley. Governor - Anlhony G. Brown, Lt. Governor - Joshua M. Sharfs1ei n, M.D.. Secretary

March 5, 2014

Attn Sytina Smith, Administrator
Forestville Health and Reh abilitation Center
7420 Marlboro Pike
Forestville, MD 20747

Dear Ms. Smith:

This letter is to acknowledge receipt of a license fee of $7,000.00 and an application to operate Forestville Health and Rehabi litation Center

The enclosed license will be in effect until April 19, 2016, unless revoked. It is your authority to maintain a comprehensive care facility with a licensed capacity of 152 beds under the provision of COMAR 10.07.02.

This license is to be displayed in a conspicuous place, at or near the entrance of your facility, plainly visible and easily read by the public.

The bed and room breakdown is attached.

Sincerely,

Office of Health Care Quality

TN/cjc

Enclosure: License No. 16-017
Cc: Prince George County Health Officer
Maryland Health Care Commission
Medical Care Operations Administration
Medical Care Policy Administration
Myers and Stauffer
Lynda Lazaro
Patti Melodini, Survey Coordinator
License File

The room and bed breakdown is as follows:

Room and bed breakdown :

CATEGORY	LOCATION	TOTAL
Comprehensive Care Facility	First Floor	
	West Wing	
	Duplex Rooms : 113, 114, 116, 117, 119, 120	12 beds
	Triple Rooms: 102, 103, 105, 106, 108, 109	18 beds
	Total **West Wing**	30 beds
	North Wing	
	Duplex Rooms: 125, 127, 128, 130, 131, 132	10 beds
	Triple Rooms: 135, 136, 138, 139, 141, 142	18 beds
	Total North Wing	28 beds
	East Wing	
	Duplex Rooms: 154,155,157,158	08 beds
	Triple Rooms: 146,147, 149,150	12 beds
	Total East Wing	20 beds
	Total First Floor	78 beds
	Second Floor	
	We st Wing	
	Duplex Rooms: 205, 206, 208, 209, 213, 214, 216, 217, 219, 220	20 beds
	Triple Rooms : 202, 203	06 beds
	Total West Wing	26 beds
	North Wing	
	Duplex Rooms: 224, 225, 227, 228, 230, 231	12 beds
	Triple Rooms; 235, 236, 238, 239, 241, 242	18 Beds
	Total North Wing	30 beds

East Wing

Duplex Rooms: 246, 247, 249, 250, 254 255,257,258	16 beds
Total East Wing	**16 bed**
Total Second Floor	**72 beds**
Overall Total	**152 beds**

SECTION A LONG TERM CARE PROVIDER APPLICATION

APPUCANT INFORMATION E-mail Fax 513-530-1646

Name of facility Telephone No 301-736-0240

Location '74

½{e..'Shi \\e.. Y{1Ac..o Geor t':> 074'7

(City) (County) (Zip)

RECEIVED
FEB 18 2014
OFFICE OF HEALTH CARE QUALITY
STATE OF MARYLAND

TYPE OF BUSINESS ORGANIZATION

D Individual U Partnership }(Corporation ☐ Association ☐ Other:_ _ _ _ _ _ _ _ _ _ _

TYPE OF COt TROL)(Proprietary D Voluntary on-Profit: D Church ☐ Other (Specify)

D Government Unit : D State ☐ City D County

LEASING ARRANGEMENT (If an entity operates the business under a lease, the followin, section shall be completeil):

Lessee ame(s) and Address(c · '14'1,0 IY\:xA 'u. <:t-.J1\\e lA.A:D -;.;;i.o'7 Lt

Less or Name(s) and Add LLC..,..· '-\700 As ur. 'S\-c. -;;ioo n--h- O\+ 4S" 4. \

Expiration Date of Leas e -1!. .J....l..i...=

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

Administrator S'\--\-1n Srn\M Admin is trator License No: R \<? Lt

LO G TERM CARE FAC ILITY TYPE

)(Nursing Home Comprehensive Care facility ☐ Does facility operate a special care unit?

0 Hospital Extended Care f-;tcilily D YES: Type_ _ _ _ _ _ _ _ _ _ _

Number of Beds_J ?d) Number of 13cds_ _ _ _ _ _ _

,R om & Bedbrea kd ow...:!,a -tt _ ch cd _ 'il..VU \a\+A 10

The 2-ycar license fee of$ '7,000 (sec 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: I - 50 beds, $3,000 51-99 beds, $5,000 100+beds, $7,000 Transitional care unit, $600

uwe o..r\e s R. S\-o\.\--z O..v;! 'd-:,,-e,\ , D.nCH µ /Io l5

(Please Print)

certify that I am/We are 18 years of age or older and of reputable and responsible character do here by apply for a license lo maintain and operate a facility subject to the pro/isions of Health-General Article, Title 19, Subtitle 3, Annotated Code of Maryland, and to the regulations adopted there under y tJ1c Secretary of Ith an en tal ygiene.

I. **Signature of Applicant**-h :::::J :L,,Y ':/,£-q—Tillc_ C J' o'

2. **Signature of Applicant**_ Title_"\JP l C Df\-\Yo\\-e.r

Sworn and subscribed to before me this 17th day of February, 2014 a Notary Public for the State of Maryland.

My Commission expires 7|28|17

Notary Public

NOTARIAL SEAL
STATE OF OHIO

Monica R. Humbert
Notary Public, State of Ohio
My Commission Expires 07-28-2017

SEND COMPLETED APPLICATION TO:

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

FOR OFH CE USE ONLY

D Initial	Date:_ _ _ _ _ _ _ _ _ _ _	A mt PD: _ _ _ _ _ _ _ _ _ _ _
☐Renewal	Ck#: _ _ _ _ _ _ _ _ _ _ _	Coord Name: _ _ _ _ _ _ _ _ _ _
D Change of Owner ship	Registration #:	License#:

STATE OF MARYLAND

DHMH

Ma ryland Departme nt of Hea lth and Mental Hyg iene
Office of Health Care Quality
Spring Grove Center • B land Bryant Build ing
55 Wade Avenue • Catonsville, Maryland 21228-4663
Martin O' M:illcy. Governor - Anthon y G. Brown, LI. Governor - Joshua M. Sharfstein, M.D.. Secretary

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RENEWAL APPLICATION PACKET
FOR COMPREHENSIVE CARE & EXTENDED CARE FACILITIES

A renewal application packet must be submilled to the Long-Term Care unit 60 days prior to the license expiratio11 date of all comprehensive care and extended care facilities. The complete renewal application packet must be submilled to the Department to complete the renewal process. Please provide all required signatures and nota1y on the appropriate forms AND include your /icensure fee based on the LONG-TER.lvf CARE PROVIDER APPLICATION. Make checks payable to: Ma,yland Deparlment of Health and Mental Hygiene. If you need additional information or have questions, please call 4 / 0 -402-820! .

VA. Application for Licensure
Room and Bed Breakdown is required at the time of license rene..val

S. Principa l Physic ian Agreement & Relief Physician Agreement

Jc. Director of Nurs ing Agreemen t

O. Facility Ownership (Medicaid Appl ication) '

/E. Sta te Affidavit

/ F. Wo rkers' Compensation Law Quest ionna ire

·1- Certifica te of Co mpliance, as app lic a ble Nf\

t V\-0 s(I,<.'.-nvL \.\: _ _

V 3C- Adverse Legal Action s/Co nvictions

/ 3 Chain Home Office In format io n

Qyu".

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[1] If not a Medicaid provider, only submit the "Provider Ownership and Control Disclosure form"

SECTION B- LONG TERM CARE PROVIDER APPLICATION

PRINCIPAL PHYSICIAN AGREEMENT

Name of Facility: [illegible] License#: f{p-{)/1

NOTE: *Tim la e Dept me11 '-Jen eg u ll wC requi re that each Comprehensive Care Facility 10.07.02 arrange for a physician to serve as a Principal Physician and a qualified relief to cover periods witen his or her services are not available.*

As Principal Physician I agree to the following:

1. *I will determine that all residents admitted to the facility are admitted upon the recommendation of and remain under the care of a physician who can provide physician services to the patient as described in these regulations and in the faci lity's policies, and works with the facility to correct problems.*

2. *As necessa,y, I will advise the administrationas the suitability of residents to be admilted or retained in the facility.*

3. *I will provide medical direction and coordination of the facility's medical care.*

4. *I will respond to emergency calls for physician services when the resident's attending physician is not available.*

5. *I will participate in the development of patient care policies, at lease annually. I will participate in the r iew ofpolicies to ascertain that the facility's operations are consislent with its written policies.*

6. *I will be responsiblefor the surveillance of employee's health program.*

[signature] 2/10/14

Principal Physician (signature) *Date*

Principal Physician Information (please type of print)

Name: [illegible] el [illegible]

(First) *(Middle)* *(Last)*

*Medical License **Number:*** D0052865

Address: [illegible]

Cily: [illegible] *State:* [illegible] *Zip code:* [illegible]

Telephone Number(,;): [illegible]

SECTION B - LONG TERM CARE PROVIDER APPLICATION

RELIEF PHYSICIAN AGREEMENT

Name of Facility: Forestville Health and Rehab Center **License #:** 16-017

NOTE: *The State Department of Mental Health requires that each Comprehensive Care Facility 10.07.02 arrange for a physician to serve as a Prillcipal Physician attd a qualified relief 10 cover periods when his or her services are IIOt available.*

As Relief Physician I agree to the following:

1. *I will determine that all residents admitted to the facility are admitted upon the recommendationof and remain under the care of a physician who can provide physician services to the patient as described in these regulations and in the facility's policies, and works with the facility to correct problems.*

2. *As necessary, 1 will advise the administrationas the suitability of residents to be admitted or retained in the facility.*

3. *!will provide medical direction and coordination of the facility's medical care.*

4. *I will respond to emergency calls for physician services when the resident's attending physician is not available.*

5. *I w'ill participate in the development of patient care policies, at lease annually. I will participate in the review of policies to ascertain thatthe facility's operatio11S are consistent with its written policies.*

6. *I will be responsible for the surveillance of employee's health program.*

Relief Physician (signature) — *Date* 2/10/2014

Relief Physician Information (please type of print)

Name: bijt (*Fir. t*) (*Middle*) PISHOA (*Last*)

Medical License Number: [illegible]

Address: 12?:8 Southern Ave S/3

Ci v: LJ4 j:IZZ *State:* Z> *Zip code:* _,Z_2(_e_J2_

Telephone Num ber(s): £ /J/2----!5-(t2,-- 0 '--1-d,"2' - - - - - - - - - -

SECTION C- LONG TERM CARE PROVIDER APPLICATION

DIRECTOR OF NURSING AGREEMENT

Name of Facility: Forestville Health and Rehab Center License #: 16-017

****

This is to .certify that I, [illegible] ama

A. **Registered Nurse, registry nWTiber** [illegible]

B. Licensed **Practical Nurse,** Board of Nursing registry number _____

and employed a tircctor **OfNursing** for the above-name facility and carry the supervisory responsibilities J,.. this po s iti on as described in StateRegulations 10.07.02 par. 12 C & G.

My agreement\ ith the **Administrator** requires that I be on duty _____ days per week and w minimum of40 hours perweek.

n irecw if fl ursing (signature) 01/28/14 Dt11e

****

The above statement is correct and in accordance with the conditions under which

Dodlyn Buck **is employed by this facility.**

(Director of Nursing)

Facility Administrator (signature) 01/28/14 *Date of Agreement*

****

MEDICAL CARE PROGRAM* PROVIDER APPLICATION

IMPORTANT: PLEASE READ ATTACHED INSTRUCTIONS BEFORE COMPLETING APPLICATION

1) APPLICATION TYPE:

D New Enrollment

Existing Provider/ Provider Number Medicaid [redacted]

I am applying as a .. Please check one:

Requested Enrollment Begin Date

D Group

D Individual/Practitioner - Solo Practitioner or Member *of* a Group (*Please circle type*)

1XJ@i stitution/ Business/Agency *(Please circle type)* [redacted]

2) PROVIDER INFORMATION

' Please refer to the instructions for the appropriate codes.

Group/Facility/Business/Agency Name		Fiscal Year End Date
Marlboro Leasing Co., LLC d.b.a. Forestville Health + Rehabilitation Center		12/31
Physician/Practitioner Last Name	First Name	Title
Contact Person Name and Telephone Number	E-mail/Website Address	
[redacted]	[redacted]	
Primary Practice Address	Suite Number	Handicap Access
[illegible]		
City	State	Zip Code
Forestville	MD	20747
Telephone Number	Fax Number	county Code / Provider Type Code
301-736-0240	301-736-1129	1 LP / 62
Employer Identification Number	Name of EIN Owner	Social Security Number
[redacted]	[illegible] Co.) LLC...	

3) LICENSE/PERMIT INFORMATION

License/Permit Type	State Issued	License/Permit Number	Issue Date	Expiration Date
Medical				
DEA				
MDLAB				
CUA				
NABP				
Pharmacy				
Other				

SECTION D • MEDICAL CARE PROGRAM• PROVIDER APPLICATION

8) MEDICARE INFORMATION

Name	Medicare Number
Forestville Health+ Rehab Ctr.	[redacted]

9) ALTERNATIVE ADDRESS INFORMATION

Pay to Address

Add,ess

rn, State Zip Code

Correspondence Address

Add,ess

City	State	Zip Code

Would you prefer to receive electronic correspondence, including remittance advices, in lieu of paper, when available? YES 0 NO

10) OTHER PRACTICE LOCATION INFORMATION

Pleaseenter other locations where you service Maryland Medicaid recipients. Include all group addresses you are currently practicing under, if applicable. •p1ease refer to the instructions for aoorooriate codes.

Practice Address #2	Suite Number	Handicap Access

City **Stale** **Zipcode**

Telephone Number	• County Code	License Number Expiration Date

Practice Address #2 Suite Number Handicap Access

City State bpCode

Telephone Number	*County Code	License Number Expiration Date.

4) PRACTICE INFORMATION

- Please refer to the instructions for appropriate codes.

• Type of Practice	"HMO Type Category
\ 0	_____ _____

5) SPECIALITY INFORMATION

- Please refer to the instructions for the appropriate codes.

Primary/Secondary Specialty	' Specialty Code	Certification Date	Certification Number

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:

D 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.

D 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.

D 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.

D 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.

D 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

Group Name	Provider Number	Begin Date

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, hat I or my group will not bill the Maryland Medical Care Program for those services for which I *or* my group is salaried.

Date 2 / n 11-1

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

Charles R. Stoltz

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

SECTIOND· PROVIDERAPPLICATION' PRACTITIONERAND GROUP ADDENDUM

PRACTITIONER NA

If you are participating in a grouppractic,edo youalso provide care to Maryland Medicaid recipients in your private practice and wish to be reimburseddirectlyby the State? (Yourpersonal tax identificaiton number must appearon this applcaton)

☐ YES ☐ NO

GROUP NA

If your group is affiliatedwith a health care institution or medicalschoo,lplease 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 ______________________________

Addre_ss _

Title_ _

Duties _

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

If you are aM.D. or 0.0. will you be dispensing phannaceulicalsother than samples (as a pharmacy)? D YES D NO

If you are an 0.0., are you practicingoptometry exclusively? D YES D NO or optometry as well as preparing and dispensing eyeglasses (as an optician)? D YES D NO

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

Is your group operating a Freestanding Clinic D YES D NO

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

LABORATORYINFORMATION N·

Completion of this sectionis 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 CUA Certificate and, when require,dMaryland Laboratory Permitsor Letters of Excepiton.Pracittioner providers cannot be reimbursed for services referred to medical laboratories or other practices. Those laboratories or pracitces must bill.

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

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

Do you receive specimens that are obtained from othersites located in Maryland? D YES D NO

All Maryland pracitioners 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 CUA Certificate Numbe, if they do not receive specimens that originate in Maryland.

SECTION D- PROVIDER APPLICATION" INSTITUTION ADDENDUM

Your Fiscal Year End Date 12|31

Bed Data

Service Type	Number of Beds
Intermediat Ceare (ICF)	
Acute Inpaitent (INP)	
Skilled Nursing (SNF)	,CS
Chronic Hospitla (CHB)	
Mentla Retardation (MR)	
Olher (OTH)	

DIALYSIS FACILITIES

Medicare Provide Number _ _ _ _ _ _ _ _ _ _ _ _ _

Attach a copy of letter with assigned Medicare Provider Numbe.r

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 portabliity? 0 YES O 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 CUA 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 D NO

Do you provide medical laboratory services for other than your own patients? D YES N?

Do you receive specimens that are obtained from other sites located in Maryland? D YES ,M' 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 CUA Certificate Number (Clinical Laboratory Improvement of 1988 Pubilc Law 100-578) to perform laboratory services. Out-of-state providers are only required to provide their CUA Certificate Numbe,r if they *do* not receive specimens that originate in Maryland.

PLE ASE COMPLETE FORM DHMH 4126 -G, PROVID ER OW NERSH IP AND CONT ROL DISC LOS URE FORM, A D S UBMIT WITH PROVIDER APPLICATIO N.

SECTl0N D

PROVIDER OWNERSHIP AND CONTROL DrSCLOSURE FORM

rlboro Leasing LLC

Name ot your Medical Seryic of Supply provider Ownership (ascontamed on your application

{Applicable to all Providers of items or services except for individual praciiiioncrs .or groups or practitioners "

Pursuant to 42 CFR "455.100 et. Seq., the disclosure of the following is a required portion of the Maryland Medicaid Provider Application. Therefore, pleese answer the following questions and sign this document affirming that this information is true and complete, and return with your application. If necessary, please attach continuation sheets

A. Name any person who. with respect lo the Title XIX Provider":

1. is an officer or director
Sf-eph-eJ0 L. R...0sed0, l.e Charles R. Stoltz, Ronald S. Wilheim

2: is a partner

3. has a direct or indirect ownership interest" of 5% or more
Ot'Y\ <;;. R G.. L-ee; S: t nc..: G, , LL.C. S+-eph t0 L. Rosedale Charles R. Stoltz, Ronald S. Wilheim, Isaac Rosedale

4. has a combination of direct and indirect ownership interests equal to 5% or more in the Provider
Same as #3 above

5. is an-owner (in whole or in part) of an interest of 5% or more in any mcirtgage, deed of trust, note. or other obligation Secured (in whole or in part) by the Provider or its property or assets if that interesl equals at least 5% of the value of the;>:-::;ierty cir assets cf lhe Provider

Orege Healthcare Investors, Inc.

B. With respect to any subcontractor in whicl:r the title XIX Provider has, direcily of indirectly, an ownership or control interest of 5% or more; name any person who falls within A. 1-5 above, as applied to the subcontractor and speciiy which of the a:iove categories he f? Is within
C-.. l ho •. re '_. Marlboro Mgmt Co, LC
Resident Care Consulting Co., LLC

C. 1. If any person named in response to Part A. 1-5, *above,* has any of the relationships described in that Part with any Trtle XIX Provider of items or services other than the applican or with any entity that does not participate in Medicaid but is reciuired to disclose certain ownership and control iniormalion because of participation in any of the programs established under Title V, XVIII, *or* XX of the Social Security Act, state the name of the person, the name of the other Provider, and the nature of the relationship
<-;-et cdf,<:., c 1-\ \ I S7 · r7; L L n I'.U..QI

2. If the answer to Part C. 1. above, contains the names of more than two persons, state whether an.v of.ih so reported are related to each other as spouse, parent, child or sibling,

parent + child

SECTI ON 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 , a nd that the requested information will be updated as changes occur. I further cenify 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 transact ionsv , occurring during the 5-year period ending on the date of such request. between the Provider and any wholly-owned supplier[111] or any subcontractor.

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

D :": ;p of 0 t';,ed fo,d;cect paVeot _____

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CFO

POS I TI O N

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[1] "Pro vider" or ·provider· of services means a hospital, a skilled nursing facility, an intermediate care facility, a dinic,a psychiatricfacility, a mental institution. an independent clinical laboratory, a health maintenanceorganization. a pharmacy, *and* any other entity that furnishes or arranges for the furnishing of services for which payment is claimed under the Medicaid program. II does notinclude individual practitioners or groups of practitioners.

' "Group of practitioners· means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities. common supporting staff, or common equipment) but who have not formed a partnership or corporation and are not employees of a person, partnership or corporation. or other entity owning or operating the heallh care facilitiesat which they practice.

• Identify any persons named, who are related to others named. as spou,se parent. child or sibling.

" a. ·o wnership Interest" means the possession of equity in the capital of, stock in, or of any interes t in the profits of the disclosing entity.

b. "Indirect ownership interest"means any ownership interest in an entity thal has ownership interest in the disclosing entity. This term indudes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

c. "Determination of ownership or control per centage·
   1) Indirect ownership interest - The amou nt of ind irect ownership interest is determined by multiplying the percentages of ownership in each entity. For example. if A owns 10 percent *of* the stock in the corporation which owns 80 percent of the stock of the disdosing entity. **A's** interest equate s to **an 8** percent indirect ownershpi interest in the disclosing entity and must be reported. Conversely, if B owns 80 per cent of the stock of a corporation which owns 5 per cent of the stock of the disclosing entity. B's interest equatesto a 4 percent indirect ownership interest in the disclosingentity and need not be reported.
   2) Person with an ownership or control interest - In order to determine percentage of ownership, mortgage, deed of trust, note. or other obligation. multiply the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A"s interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent *of* a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Significant business transaction·means any bus iness transaction or series of transactions that. during any one fiscal year. exceeds the lesser of S25.000 or 5 percent of the total operating expense of a provider.

'" ·s upplier"'mean s an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsrbilities under Medicaid (e.g.. a commercial laundry. a manufacturer of a hospital bed. or a pharmaceutical firm).

SECTION E - STATE AFFIDAVIT

Whoever knowing and willfully makes or causes to be made a false statement or representation on this statement may be prosecuted under applicable State law s. In addition, knowing and willfully failing to fully and accurately disclose the information requested may result in denial of a request to become licensed or, where the entity is already license, a revocation of that license.

I certify that the administrative and procedural requirements contained in COMAR 10.07.02 (Regulations governing Comprehensive Care Facilities and Extended Care Facilities) in the areas of written administrativeand resident care policies, By-laws and other organizational docum entation , written agreements with outside resources/consulta nts, committee meeting s, staff qualifications and written development program such as inservices, equipment maintenance and disas ter prepa redness have not been substantively altered, revised, or modified, since the previous survey, or if they have, l have notified the Office of Health Ca re Quality, in writing, before the effective date of the change. I further certify that 1 will notify the Office of Health Care Quality if there are any future "substantive changes in facility management and operation," as defined in the instructions for completion of the Federal affidavit, that significantly affect policies and procedures and that notice will be given in writing before the effective date of the change.

NAME OF FACILITY:

Forestville Health + Rehabilitation Center

Signature of Authorized Official	Title	Date
	CFO	2 /7

SECTION F WORKERS' COMPENSATION LAW QUESTIONAIRE

Name of Facility

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(Please type or print)

Address of Facility

7420 Marlboro Pike, Forestville, MD 20747

(Please type or print)

Do you have Workers' Compensation Insurance for your employees?

(Check One) A **YES** D **NO**

If you have answered **YES** above; please provide the following information:

Policy Number: (:.,3- zq -LfY-9 11.F5 -0 - I 3

Binder Number: _____ _______________

Insurance Company: _ <l".lsob..:fl,t;";= - _ - - - - - - - - - -

Effective Date: _ _ l.f.:.../f-..l.l c'--4/1 B _ _ _ _ _ _ _ _ _ _ _ _

Expiration Date: _ _ _y ..:-+-l/'1:- _l/ Y

If you have answered **NO,** please attach a copy of your Certificate of Compliance in accordance with State Workers' Compensation Laws.
(See attached form A52 and Instruction Sheet)

Please note

Your license cannot be issued unless this form is completed, signed, dated and provided to **this Administration along with your "Certificate of Compliance"** if

Signature z/n/1'1

Date

SECTION I: ADVERSE ACTIONS/CONVICTIONS

This section captures information on adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable adverse legal actions must be reported, regardless of whether any records were expunged or an appeals are pending.

ADVERSE ACTIONS THAT MUST BE REPORTED

Convictions

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include:

   Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Act.
2. Any misdemeanor conviction, under Federal of State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connections with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal of State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any misdemeanor conviction, under Federal of State law, related to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any misdemeanor conviction, under Federal of State law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation of suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

SECTION I: ADVERSE ACTIONS/CONVICTIONS (continued)

ADVERSE LEGAL HISTORY

1. Has your organization, under any current or former name or business identity, ever had an adverse action listed on page I of Section I imposed against it?

0 YES - Continue Below	NO

2. If yes, report each adverse action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any. Attach a copy of the adverse action documentation and resolution.

Adverse Action	Date	Taken By	Resolution

SECTION J: Cf¼IN HOME'OPFlCEJNFORMATION

This sec fion c,w.tures_informa tion regarding c11ain o,rg fzafions; Tbiif iirforinatjbn will.be used to ensur.e pr0pefreii:noursement'-\'.li.e1rthe pr.ovider _s y -en_ cost r port is fiJea with tf eM'edi aid fe -for-sen,ice cont:ractor.

For more info tioq on chaln qrg pizntions , se 42 c:F:R. 421 4 4.

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...THIS PROVIDER IS REPORTING

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n. CHAI Ho iioFi,1tEAnM1N1sT1u.ToR INFORi\JATION

Health Care Facility Management, LLC — Charles	Middle Name D	Last Name Stoltz	Jr., Sr., etc.
Title of Home Office Administrator CFO	Social Security Number [redacted]	Date of Birth *(mm/dd/yyyy)* [redacted]	

SECTION J: CHAIN H0:M.E OFFJCE INFORMATION (co"ri111IJ!dJ

C. CHAIN HOME OFFICE INFORMATION

1. N11n1c of-Homc Officc 3 Ret,on&f fo t hc:lnternal R:i-vcn i.Jc ;Senliic;
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2. Home Office 81.ls im:ss S1reet Addrcs Linc 1 (S1,w 1 Na1)1 p,rd ,V1mibcr/
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City/Town	State	ZIP Code + 4
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TclcP,I1om,:Nw;nl>c r-	Fax Number (if applicable)	E-mail Address (if applicable)
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[redacted]	l;L- 3 T
4. Home Office Fee-For-Service Contractor	T.foirtc-Q.flii:cCaitinNiuiibcr [redacted]

D. TYPE OF BUSINESS STRUCTURE OF THE CHAIN HOME OFFICE

Che 6k orw- :

Voforl/my:

D Non-f ro"fit - R.cligiouslli ariization
0 Nnn-,Profit - othcrfSp:dM____________

0 P1:opri tary
☐ li_1'div.idual
W eo rporation

0 Part.n l:S -P:...
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Government
d Fed¢ta
EJ: Si t'e
City
0 c o unty
D Gity;.County
D l:losr,ftaJ .Dfatrfot
D Other i:'iptcif.vJ ________________

E. PROVIDER'S AFF(LIATION TO THE CHAIN HOME OFFICE

Check one:

D Jofot Ventt.trc/R¢lationship
if M-u1 gcd1Relate
0 Leased
D Qp rated/Re(atcd
0 Wholly Owned
D Other (Spt!cifj,J:____________

Prov ide r Agreement for Participatio n in Maryland Medical Assistance Program

This /\grecment (the " /\ grecme nt"). e nte red into between the Ma ryla nd Stale Department of Health and Mental Hygiene (the ··Department..) and

n]rt(\b) (a L t>c&\YJ \(Co.) u. c.. OLb (. rt' \\R \.-\.fcJ...U..1-;- Q t.µp, \11:i?'-hUV\ Ca d,e.e_ \:>) CY\Or\es R., !b \+ -z..

the undersigned Provider or Provider Group a nd its membersor Practitio ner(s) (herei nafter called the '·Provider"). is made pursuant to T itle XIX and Title XXI of the Social Sec urity Act. Hea lth-G eneral. Title 15, Annotat ed Code or Maryland and state reg ula tions promulgated thereunder to provide medical. healthcare . home- and community-based serv ices and/or remcdinl care and serv ices (..Se rvice(s) ..) to eligi ble Marylaml Medical Assista nce recipi ents (" Rceipicnt(s)"). On its ctlcctive date. t his Agreement supersedes and replaces any existing contracts between the parties relntcd to the provision of Se rvices to Recipients.

I. THE PROVIDER AGREES:

A. To comply with all standards of practice. professiona l s tandards and le vels of Service as set forth in all appli c able federal and state laws. statutes. rules and regulations. as well as all administrative policie s. procedures. transmi ltals, and guidelines issued by the Department. including but not limited to, verifying Recip ie nt eligibility, obtaining prior authorizatio ns. submi tting accurate. complete and timely c laims, and conducting business in such a way the Recipient re tains freedom of choice of'providers. The Provider acknow ledges his . her or its responsibilit y to become familiar with those requirements 11s they may differ signilicnntly from those of othcr third party payor programs:

13. To maintain adequa te medica l. tinanc ial and administrative records that fully justify and describe the nature and extent of all goods and Services provided to Reci pients for a minimum of six years from the date or payment or longe r if required by lmv. The Provider agrees to provide access upon request to its busi ness or facility and all related Recipie nt information and records, includin g cla ims records , to th e Department. the Medicaid Fraud Cont rol Unit (M f CU) of the Maryland Attorney Gene ral' s Office, the U.S. Departmen t of I lca lth and Human Services. and/or any of their respective employees. designees or authorized representatives. This requirement docs not proscribe record req ui rements by other laws. regulations. or agreements. It is the Provider' s responsibility to obtain any Recipient conse nt required to provide the Department, its desig nec, the MFCU, l'cderal e mplo yees, and/or dcsignecs or autho rized representatives with requested information and records or copies of records. Failure to timely submit or failure to retain adequate documentation forservices billed to the Department may result in recovery or payments for Services not adequa te ly documented. and may result in the termi nation or s uspension or the Provider from participation as a Medical Ass ista nce provider.

I. Or iginal records must be made available upon request during on-site visits by Department pcrsormcl or personnel of the Depa rtment·s desig nee.

2. Copies or records must be time ly forwarded to the D1:partmc nt upon written request;

C. To prorecqbe· cbnfideµtiaHty of U Recipient infonnatfon in ao-cordance w1ththeterms, conditions and requirements of-the Health Tnsurarice ¥on-ability and Accountability Act (HIPAA) of 1996, as amended, and ret1.llationsadoptedt11cteundet contained in 45 CFR 160, 162 and 164, and the Maryland Co nfidential ity of Medical RecordsAct (Md. Ann. Code, Health-General *§§4-*30-t *et seq.)*

D. To _provide _t.yice s.o rr.a.nop;,qi pimir:ito ry basis ud to holdhar:mless; indenmicy:anq dere11d -Depa.rtmen-from.all negli etitor intentionally d trimenmlacfs uf the Provfder, its agents and mpl9.y<!es. Th e .Prov iderwill not·discriminate on the-basisof race·, color; national origin; age, .religion, sex, disabilities, or sexual orientation;

E. t -0. provideSe:rvices in compliance with the .Afnericanswith Disabilities •Act of 1990, S tion 504·of0 e R¢liab,_ilitafion Aatof 1973.an tbein:espeGtive aGcom_pany.ing re "l:llations; .and·e;nsure tbat-qua1fiied'.individuals··With 'disabiltiies-are-given an oppqryµ. ity *tp* .garti ipate.in.:.cmd· benefit *ftQ.tµ* its'$eryl ces; irtclud.ing p rnv.i ingdnterpreifve!sendces *fot* .the:<leafano·1,.-ard of heating when required,

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G. To acce-ptthe:Depamnent-'s payrii nt-s pa}'n1enr in fiillfo.t covered:Servi\: ·rendete.dto a 1{ ipi .nt. '(,};_ P.rovider awees not to 6ill, retain, t>t accept any a:ddit©nal payment ffqrp any Recipient If th t>epc_1.t:tm nt dehies payment or reqoes.ts p.aymen(from the.Recipient, or if the Departmen tc;le nies paymertt or-requests repayment because an otherwise co,ered:Service was not medically-necessaryor was riot preauthorized (if required), the Provider ag ees-not to seek payment froti1 the Recipient for'that Service. Tbe Provider farther agrees·to immedi tely repay the Departri.1ent in full for.any claims.whe-rethe Provider receivedpayment rrom anotherparty after being paid by the Department;

H, With.tl1eexGep t:0110.f prenatal care o r preventive pediatric care, to seek payment from a Recipient's·other'insuranc-esaml:Tes.ourccs of payment before-submitting claims to the D partment, which includes but is not limitecl to seeking payment from Medicare; private insurance, m.e.dicaJ benefits provided by employers and unions, worker compensation, and any

qther third party insuran_ce. If pa)'mcnt-.i's. made by both.theDepartment and..the Recipi nt's other insurance,.the Provider shall refund the Department, within 6Q days of receipt,.the amount paid by the Department;

I. To accept,resp onsibiJ.ity,*fot* the v-alid ity anci acqu racy of al! cj.lai:ms SJ.ibm itted to the Department, wh _th.ersubmift d on.paper, elec.tronicailyot·through a billing servtce;

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-r<:. That'tf:Providet is a physiqfan,.lieor$he will. upori-.request .submit ihe-name ud applicabie licensµr for ea-eh pbysidan exfunder'in his or heremployin nt Th¢'.Prqvider is tespousi-ble for knowiugan omptyiijttwitb-,1! M ryl&ncl Medical Assistance Prcrgta m. s def.Jnitfom cif arI eligibl(!physrcian extender and fdt.prbvicH.ng sape rvisrdii'as r.eqttired by the Maryland Medical Assistan Programj

.L. That in t ase of a group provider, the ii1diiidua1 P.to,iiderrendi:iQg the service hall.include his or her o,wn prqvicier m1m.ber; as:,well as the group provider number() , a any cfaim;

M To fiirnish the De'pamie:nt,\ .itJ.lfo:) S-d Y.s of ;w. Oepartment!s reques:t,full-and complete: m formation.ahdut:

1. The ownership of anysubcontractor wi,th-whom the Rrovider has had business transactio11S to.ta ling:cno:ie than$25,000 during the 12-monthperiod ending ort the dateof thereque-St
2. .Any sigJi:icavt business transaction between tlie Proviaer d any w holly-owned sJipplfo:r, br oerwee1Uhe P.rovide a n h n y subcontractor, during the 5- ear period ending on the cfatc of th-e request; an'd.
3. Any owne.rship interest exceeding S- percent heH:i by the Provider in any other Medical Assistiln¢.e Prov-ider;

N . That before the Depadment nters into or renews thi's Agte-emeot, the Provid r grees to disclose .the iclentity of any person who.

1. }:(as anownership or control interest in the Provide.r-,oris an agent.or managing employee. of theP:to-videt; and
2. Has be-n convicted of a:criminal-offense related to that person 's inv9!vement in tne Medicaid or Medicare pi:ograms;

0. To exhaust.all administrative remedfos prior to initiating any IitigatiQn ag ainst the Deparlment;

P. Upon-receip ofnptific,atio.n that the Provider is disqualified through any federal, state-and/or Medicaid admfmstrative ac ioQ, to- notsμbmitclaimsforpaymentto-the . D ep arrment forServices perfonned,after the;dlsqual fibatfondate;

Q. Any excessive payments to a Pr-0yider maybe immedfaleJy cieducte from fiiture;Department paymei:tts to-a:ny11ayeewith :hq P,ro jaer-'st x. iden:tifip-aticm number, at-th-edisctetioR ofthe Department;

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tJ. To notify theD¢partm. nhvifhin,f tve (5) worki g:clays of.any-o'f't'!1 followin.g:

1. f\.ny actioμ which may result jn the suspension, revocatiQJ• co ndition,.limitation, qualification or othermatedal restri.ctfon on a P'rovider s'licenses, certifications:; permits or staff privileges by any enthy under whicha Provider is auth0-rizedto provide Services includin g i ridiciment, arrest; felony convicti9i;i or any cn minal charge;

2. Char1gefo corpora.te e11tlty; se rvfoib-glo cations,mailing address or addition to dr temovaI of practitioners or aqy qtf1 r rnfonna tion pertinent to lhe receipt of Departm ent funds;.or

3. Change i-nownershipinclt,1ding full disclosure of the tem1s of the sales Agreement. When there is a change in owne1 ship, this Agreement is automatical1y assigned to the new

owner, andJhe ne-wownershall, asa <:tmdition of.participation, assurile-lia'bi'lity;jointly and severalfy with the-prior o,.,r,ter for any and all amounts that may be-due, or become due-t9 the.0-epa.rtment,-and such amounts may be witbh:eld. from the payment ofcfaims subniitted when detetmin d. (NOTE: Sectior·i 1.·s.3 does not apply to Nurs ing Home Provld rs)

II. THE DEPARTMENT AGREES:

A. T-o..reimburse tb,e-Provid erfor medically nete;ssary Services provided to Ripients tb t are c9ver-ed by the Maryland MedicaJ.Assistanc-e Pr-0grarr1. Services "Yill be. .reimbursed in·accorp nd, c: ,,;itlrnll F{qgr?Jn ,r gi.ilaJfotis and fee.schedules,as·r. flected in-tlie-Code·of Mar-yfa.nd Re gulatibns oi::iot het rules,- ction trans mittals or.guidance issued bd he-b epa i:trlient; ai1i;l

B. To provide notice o'fc}v.mges in }:>rogram.regulat1o thrcrugh publicatfon in.the Maryland Re.$ister,.

III. T:HE DEP-ARTMENT D P OVIDER MUTUALLY AGREE:

A, T xcpt.as_spe,pi':p<;;lly p.rnvip .t'Qth rwis in applicable law and regulations, either PaitY. ·may. termh111tc this.Agreemenfl?Jgivi.pg·tliiil-y (30) -days notic;e in writing to,th otp_er party After-·tean inatio-n, the- Provid'et-sball.notify Recipients before rebqering.addi.tidrl I Se rv.ices t,hathe.or·she·is no longer. a Maryland Medical Assistance.partidpating P.rovider;

B. That j..he·effe ffve oatof.this Agreement shall be._____– provided that the O-ep artment'.verifies:tt1:e-infonpafion iq the rovi ·r·s applicat fon, This A,grec !!nt shall main in:ef'fect unttl·eillierparty.terminates the Agreement(as descrl in S ctiori)ll A}. Fpll<;,\vfog teri:flinatjo of-@s Agceemenf,the Provider must nfi"nue to·r.eia:irrrecords and·-re iltrbur-se t he·Maryland·Medical Assistance.Prqgram fo'z: overpayments as..d ?cribed.-in this Agreement arid a·sTequ.riedby la'w including but. notlimited to Maryland Heatfu:..Ge·nral §4-403;

C. That no mploy of'the State of Maryland, whose duties includematter.s. relating to this Ptovide·r•s Agreement, shall at the same time become an employ.e·e o f the Providerwi thout the written permission ofthe Department;

D. That this Agreement is not"tr-artsfera:.ole or assignable·;

E. That the Provider Enrollmen t Application sub mitted and signed by the Provider is incorporatcd by reference into this Agreement and is a part hereof as though fully set forth here in; and

Provider Signature Date

Department Authorizatio n Date

Char les F.S:toltz
Provider Name (Ty ped) Date

Assista nt Attorney General Date

7420 Marlboro Pike, Forestville, MD 20747
Provider Signature Address (Typed)

1fH

STATE OF MARYLAND

Office of Health Services
Medical Care Programs
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor - Anthony G. Brown, Lt. Governor - John M. Colmers, Secretary

MARYLAND MEDICAL ASSISTANCE

DMS/DMEA.NI} OXYGEN

RESIDENTIAL SERVICES AGENCY SURVEY FORM

All Maryland Medical Assistance Providers of Disposable Medical Supplies (Durable Medical Equipment and Oxygen and Related Respiratory Equipment services must complete and return this form. Failure to return this document will result in suspension from Medical participation.

I certify that this organization: does_ _ _ _ _ _ does not___ _ provide any of the following medical equipment and services to Medical Assistance recipients in their residence:

- Delivery
- Installation
- Instruction
- Maintenance
- Replacement of oxygen and oxygen delivery systems, ventilators, respiratory disease management devices, electronic and computer-driven wheelchairs and seating systems, apnea monitors, transcutaneous electrical/nerve stimulators, low air loss cutaneous pressure management devices, sequential compression devices, neonatal home phototherapy devices, feeding pumps and electrically powered hospital beds.

If your organization provides these services, so indicate and attach a copy of your current Residential Service Agency license to this form along with your application and return them to the address below. If you do not provide these services, so indicate and return this form to the same address. Also, if in the future your organization begins the provision of the above-mentioned services, it is your responsibility to obtain such licensure and forward a copy to the Division of Community Support Services. Please call us at (410) 767-1739 if you have any additional questions.

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Organization Name

Name of Individual Completing Form

Forestville, MD. 20747
Address

Title

Signature

MA Provider #

[redacted]
Contact #

Contact#

Pleas e retu rn this form to the following address:

Edna Radu, Program Specialist
Division of Community Support Services
201 W. Pr ton Street, Room, 136
Baltimore, MD 21201

To obtain information concerning Residential Service Agency Licensure, you may call (41O 402-8000, or write to the Office of Health Care Quality, Spring Grove Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, MD 21228.

MARYLAND
DEPARTM EN T OF HEALTH AND MENTAL HYOIENE
OFFICE OF HEALTH CARE QUALITY
SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENU E
CATONS VILLE, MAJ{YLA.ND 21228

License No. 16-017 Registration No. 27836

Iss ued Lo : FORESTVILLEHEALTH AND REHABILITATION CENTER
7420 MARLBORO PIKE
FORESTVILLE, MD 20747

Type of l'c1cility and Number of Beds:

Comprehensive Care Facility - 160 Beds

Date Issued: April 19, 2012

This license has been granted to: Marlboro Leasing Co., LLC

Authority to operate in t[iis State is granted to the above entit_y pursuant to The Health-Genera l Article, Title 19 Sc<:tion 318, Annotated Code of Maryland, I982 Edition, and ubsequent supplements and is subject to any and a ll statutory provisions, including all applicaple rules and regulations promtilgated th<,reunder. This document is not transferable.

Expiratio n Date: April 19, 2014

Nancy B. Sturman
Director

Fals! fication of a license shall subject the perpezrator to criminal prosecution and the impositi on of civl/ fines.

E_ Lb,\- f\

Forestville

Summary of Rooms Available - 8/8/11

Category	Location	Room Type	Rooms	Total Beds	
Comprehensive Care Facility	First Floor	Private		0	
		Semi	113, 114, 116, 117, 119, 120, 125, 127, 128, 130, 131, 132, 154, 155, 157, 158	32	
		Triple	102, 103, 105, 106, 108, 109, 135, 136, 138, 139, 141, 142, 146, 147, 149, 150	48	
		Quad		0	
			Total - First Floor		80
	Second Floor	Private		0	
		Semi	205, 206, 208, 209, 213, 214, 216, 217, 219, 220, 224, 225, 227, 228, 230, 231, 246, 247, 249, 250, 254, 255, 257, 258	48	
		Triple	202, 203, 235, 236, 238, 239, 241, 242	24	
		Quad		0	
			Total - Second Floor		72
	Third Floor	Private		0	
		Semi		0	
		Triple		0	
		Quad		0	
			Total - Third Floor		0
			Total All Rooms Available		152

Legal Name	Facility d/b/a	Street	City, State, Zip	Phone	Fax	Type	Medicare #
Souto III Leasing Co., LLC	Advanced Specialty Hospitals of Greenbriar Rehabilitation	8064 South Avenue, Suite 1	Boardman, OH 44512-6153	Ph: (330) 965-6432	Fax: (330) 965-6438	LTCH	360349
Gar e_:1II Leasing Co., LLC	Advanced Specialty Hospital of Toledo (LTACH)	1015 Garden Lake Parkway	Toledo, OH 43614-2798	Ph (419) 38.E 0J.3Z._	Fax (419) 381-? O i	IRF	363032
F:? nt Leasing Co., LLC	Aristocrat Berea Skilled Nursing & Rehab Ctr.	255 Front Street	Berea, OH 44017-1943	Ph (440) 2_3-4__	Fax (440) 234-0819	SNF/ICF	365608
ylfne (PA) Leasing Co., LLC	Baldwin Health Center	1717 Skyline Drive	Pittsburgh, PA 15227-1744	Ph: (412) 885-8400	Fax: (412) 885-0772	SNF	395745
Bel Pre Leasing Co., LLC	Bel Pre Health & Rehab Center	2601 Bel Pre Road	Silver Spring, MD 20906-2313	Ph: (30_ 98 - 000_	Fax: (301) 598- 678	SNF	215065
Sheldon Leasing Co., LLC	Berea Alzheimer's Care Center	49 Sheldon Road	Berea, OH 44017-1136	Ph: (440) 34-0454	Fax: (440) 234-0494	SNF	365893
Liberty Leasing Co., LLC	BridgePark Healthcare Center	4017 Liberty Heights Avenue	Baltimore, MD 21207-7545	Ph: (410) 542-5306	Fax: (410) 664-1"._1_7	SNF	215195
Royce Leasing Co., LLC	BridgePort Healthcare Center	2125 Royce Street	Portsmouth, OH 45662-4714	Ph: (740) 354-6635	Fax: (740) 354-1443	SNF	365313
Sprin ale Leasing Co., LLC	Burlington House Rehab & Alz. Care Ctr.	2222 Springdale Road	Cincinnati, OH 45231-1805	Ph: (513) 851-7888	Fax: (513) 589-3444	SNF	365892
Belmore Leasing Co., LLC	Candlewood Park Healthcare Center	1835 Belmore Road	East Cleveland, OH 44112-430	Ph: (216) 268-3600	Fax: (216) 761-1322	SNF	365353
_wa_!er Lea ing Co., _!LC	Chardon Healthcare Center	620 Water Street	Chardon, OH 44024-1149	Ph: (440) 285-9400	Fax: (440) 285-9378	SNF	365711
City View Nursing & Rehab LLC	City View Nursing & Rehab Center	6606 Carnegie Avenue	Cleveland OH 44103-4622	Ph: (216) 361-1414	Fax: (216) 361-2822	SNF	365879
Clime Leasing Co., LLC	Columbus Healthcare Center	4301 Clime Road, Nort	Columbus, OH 43228-3403	Ph: (614) 276-4400	Fax: (614) 278-7645	SNF	365686
Garden Leasing Co., LLC	CommuniCare at Waterford Commons	955 Garden Lake Parkway	Toledo, OH 43614-2793	Ph: (419) 382-2200	Fax: (419) 381-0188	SNF	365704
Clifton Care Center Inc	CommuniCare of Clifton Postacute & Rehab Ctr.	625 Probasco Street	Cincinnati, OH 45220-2710	Ph: (513) 281-2464	Fax: (513) 281-2559	SNF	365304
Heritage Leasing Co., LLC	Copley Health Center	155 Heritage Woods Drive	Copley, OH 44321-1398	Ph: (330) 666-0980	Fax: (330) 666-5585	SNF	365771
Midland Leasing Co., LLC	Crestwood Care Center	225 West Main Street	Shelby, OH 44875-1412	Ph: (419) 347-1266	Fax: (419) 342-7035	SNF	365284
Flo-GP Leasing Co., LLC	Crystal Creek Health & Rehab Center	250 New Florissant Road South	Florissant, MO 63031-6716	Ph: (314) 838-2211	Fax: (314) 838-S981	SNF	265607
Ridge (MD) Leasing Co., LLC	Ellicott City Health & Rehab Center	000 North Ridge Road	Ellicott City, MD 21043-3311	Ph: (410) 461-7577	Fax: (410) 203-1897	SNF	215160
Falling Leasing Co., LLC	Falling Water Healthcare Center	18840 Falling Water Road	Strongsville, OH 44136-4200	Ph: (440) 238-1100	Fax: (440) 238-9575	SNF	366111
yette Leasing Co., LLC	Fayette Health & Rehab Center	1217 West Fayette Street	Baltimore, MD 21223-1938	Ph: (410) 727-3947	Fax: (410) 385-5886	SNF	215183
Marlboro Leasing Co., LLC	Forestville Health & Rehab Center	7420 Marlboro Pike	Forestville, MD 20747-4343	Ph: (301) 736-0240	Fax: (301) 736-1129	SNF	215020
Livingston Leasing Co., LLC	Fort Washington Health & Rehab Ctr.	12021 Livingston Road	Ft. Washington, MD 20744-42	Ph: (301) 292-0300	Fax: (301) 292-2986	SNF	215146
Merit Leasing Co., LLC	Grande Pointe Healthcare Community	3 Merit Drive	Richmond Heights, OH 44143-	Ph: (216) 261-9600	Fax: (216) 261-9662	SNF	366008
Southi Leasing Co., LLC	Greenbriar North Healthcare Center	8064 South Avenue	Boardman, OH 44512-6153	Ph: (330) 726-3700	Fax: (330) 726-2194	SNF	365853
:.earl i sing Co., LLC	Greenbrier Senior Living Communi! Y	6455 Pearl Road	Parma Heights, OH 44130-298	Ph: (440) 888-5900	Fax: (440) 888-0976	SNF	365192
Green Park Leasing Co., LLC	Green Park Senior Living Community	9350 Green Park Road	t. Louis, MO 63123-7211	Ph: (314) 845-0900	Fax: (314) 845-0901	SNF	265703
Avis Leasing Co., LLC	Harrover House Nursing & Rehab Ctr.	435 Avis Avenue NW	Massillon, OH 44646-3555	Ph: (330) 837-1741	Fax: (330) 837-1747	SNF	365292
Fairchild (MD) Leasing Co., LLC	Kent Healthcare Center	1290 Fairchild Avenue	Kent, OH 44240-1814	Ph: (330) 678-4912	Fax: (330) 678-1040	SNF	365834
Kolbe Leasing Co., LLC	Lake Pointe Health Center (OECC)	3364 Kolbe Road	Lorain, OH 44053-1628	Ph: (440) 282-2244	Fax: (440) 282-7709	SNF	365623
Howard Leasing Co., LLC	Marley Neck Health & Rehab Center	7575 East Howard Road	Glen Burnie, MD 21060-8312	Ph: (410) 768-8200	Fax: (410) 768-2954	SNF	215138
Rocky River Leasing Co., LLC	Northwestern Healthcare Center	570 North Rocky River Drive	Berea, OH 44017-1613	Ph: (440) 243-2122	Fax: (440) 243-4314	SNF	365811
East Water Leasing Co., LLC	Oak Grove Healthcare Center	620 East Water Street	Deshler, OH 43516-1327	Ph: (419) 278-6921	Fax: (419) 278-2910	SNF	365767
Jarvis Leasing Co., LLC	Pebble Creek	670 Jarvis Road	Akron, OH 44319-2538	Ph: (330) 645-0200	Fax: (330) 645-0316	SNF	365727
Brecksville Leasing Co., LLC	Pine Valley Care Center	4360 Brecksville Road	Richfield, OH 44286-9457	Ph: (330) 659-6166	Fax: (330) 659-2944	SNF	365370
Regency Leasing Co., LLC	Regency Manor Rehab & Subacute Ctr.	2000 Regency Manor Circle	Columbus, OH 43207-1777	Ph: (614) 445-8261	Fax: (614) 445-8050	SNF	365484
KingTree Leasing Co., LLC	Riverside Nursing & Rehab Center	1390 King Tree Drive	Dayton, OH 45405-1401	P : (937) 278-0723	Fax: (937) 278-1989	SNF	365877
Washington Leasing Co., LLC	South River Health & Rehab Center	144 Washington Road	Edgewater, MD 21037-1412	Ph: (410) 956-5000	Fax: (410) 956-0470	SNF	215297
Emery Leasing Co., LLC	Suburban Pavilion Nursing & Rehab Ctr.	20265 Emery Road	North Randall, OH 44128-4122	Ph: (216) 475-8880	Fax: (216) 587-4806	SNF	365215
Old Leasing Co., LLC	Wexford House Nursing & Rehab Ctr.	9850 Old Perry Highway	Wexford, PA 15090-9311	Ph: (412) 366-7900	Fax: (412) 366-8768	SNF	395300
Summitt (Ohio) Leasing Co., LLC	Wood Glen Alzheimer's Community	3800 Summit Glen Drive	Dayton, OH 45449-3647	Ph: (937) 436-2273	Fax: (937) 436-4771	SNF	365722
Wyant Leasing Co., LLC	Wyant Woods Care Center	200 Wyant Road	Akron, OH 44313-4228	Ph: (330) 836-7953	Fax: (330) 836-6806	SNF	365779

MARYLAND
DEPARTMENT OFHEALTHANDMENTALHYGIENE
OFFICEOF HEALTHCARE QUALITY

SPRING GROVE Cl!NTER
OLAND BRYANT BUILDING
SS WADE AVENUE
CATONSVILLE, MARYLAND21228

LI«"-"'No. 16017

ls.wed to: Forcst\•illc Hc:t lth&, RchabHitiUion Center
7420 Marlboro Pike
Forestville, MD 20747

Type:of f ACil ity and Number or Ucds:
ComJ)f"C'hc-nsivc Ca facility• 1628cds

Dale l ucd: April 19.2016

This license hus been gmnlc'<l to: Mnrlboro I.cu ingCo, LLC

A1i1lhority to<Jr(f'MIn1htl*Sulth* va,iccJto thcab,wc<:nlltypc;,:nu,anc10Th<'lf cshll--GcnMtl Mkk, Titk 19 S«tioft.lUl AnnoUiilcJ CodoeorMa.>tand.l9S2Edrl)M,andW I **and** l:sJllt,;«1 1.o 411)':ind I J.Wu&oiypmiuortl.lnclOOln& allaprltC";lbk rulo and quhdonJ pron,ulpud lhc-ttul'k.kt. lh li Jotumcni I, not IBO:lf(Qbk.

Expiration Date: April 19,2018

Patricia Tomko May, MD

Oircc1or

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S f A "t E O f-' M A R \' L A S I>

DHMH

Maryland Departmen tof Health and tvlcn1al Hygiene
Onicc of HenIth Cnrc Qualit y
Spring GroveCenter• BlnnJ Bryant Building
SS \Vl)Jt:Avenue • Cutonsvillc, Mnrylnnd 2122-8 4663
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April 7, **2016**

Attn: CalanthiaGreen, Administrator
f ore,tvllleHealthandA.chabltltaUonCenter
7420Marlboro Pike
f ore. tvlll e, **MO**20747

Dear Ms. Green:

Thisletter is to acknow1edgereceipt of a lk ens.e fee of S7,000.00 andan appllcatlo n to operate Forestvlllt Health andRehablllt11ll on Center

The enc.losed lk t nsewUI be tn eff ect untJIApril 19. 2018,unless revoked. It is your authority to maintain • comprehensivecare facility with a llctnsed capacity of 162 bedsunder the provision of COMAR 10.07.02.

Thislicensels to be displayedin a c.onspkuous plact, at or nei r the entr.,nce of your fac.llty, p lainly visible andeasily readbythepublit.

The bed*and* roombreakdownIsattached.

Sr

Margie He**ld,Deputy**Olre<1o r
OfOceof HealthCoreQuality

MH/cjc

Enclosure: Ucense No. 16-017

Cc: Princ:cGeorge CoontyHealth Offker
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calanthla Grc-cn, Admln1$trator
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Pase Two
April 7, 2016

Tho room an<lb<dbreakdown Is asfollow<:

Room and bed breakdown

CAilGOBX	LOCATION	TOTAL
Comprehensive Caro Facill1y	F111tF100<	
	Oup!o•Room" 113,114,116,117,119, 120,125,127,128,130, 131.132,1S2,154, 155, 157,158	24 bods
	Trip!o Rooms 102,103,105,106,108, 109,135,136,138, 139, 1,41 142,146,147,149, 150	48 bods
	Toto! flrnfloor	82 be<!•
	S-ndFloor	
	Slnglc Rooms: 252	01 bod,
	Duplex Rooms: 213, 214, 216, 217, 21, 9 2 20, 224,225,227,228, 230, 231,246, 254, 25S. 257,258	34 bed,
	TrlploRooms: 202,203,205,206,208, 209,235,236,238.239, 241,242, 247, 249, 2SO	45 bed,
	TotalSecond Floor	80b<ds
	OvorallToliJI	162 b<d,

SECTION A. LONG TERM CARE PROVIDER APPLICATION

APPLICANT INFORMATION — E-mail — Fax

Name of Facility: Malboro Nursing Center, LLC — Address: Malboro Pike — Phone

Location: 7420 Marlboro Pike

Forestville — Prince George's (County) — 20747

TYPE OF BUSINESS ORGANIZATION

☐ Individual ☐ Partnership ☐ Corporation ☐ Association X Other: LLC

TYPE OF OWNERSHIP: X Proprietary ☐ Voluntary Non-Profit ☐ Church ☐ Other (Specify)
☐ Government Unit: ☐ 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): Malboro Nursing Center, LLC: 7420 Marlboro Pike, Forestville MD 20747

Lessor Name(s) and Address(es): Maryland NH Asset, LLC: 4700 Ashwood Dr. St. 200 Cincinnati OH 45241

Expiration Date of Lease: Multi-year lease

Applicant's ... r.loo,rm ... or ... :ihdl 'br ... 11>' I o nittn ork ... Df;JXir.il iol!,
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Administrator: C a.fl,hl.il.Cr«n ... R.\J- — 7

LONG TERM CARE FACILITY TYPE

X Nursing Home Comprehensive Care Facility
☐ Hospital Extended Care Facility
Number of Beds ~~152~~ 162
Room & Bed breakdown attached Exhibit A

Yf;S: ... NO — Number of ... ______

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rw. ... ,:,0 hcd:J,. SJ,.000 ... 5M)9 b(,jj,, M,000 ... 1 ... $1.0COi ... fhmLIICWl.ll ... tatla. $600

I/We ... (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 [signature] Title 3/30/2016

2. Signature of Applicant ______ Title ______ Ohio

Sworn and subscribed to before me this 31st day of March, 2016 a Notary Public for the State of Maryland.

My Commission expires 10-19-2020 [signature: Donna J Griffith]
Notary Public

NOTARY PUBLIC — STATE OF OHIO

SEND COMPLETED APPLICATION TO:

DONNA J. GRIFFITH
Notary Public, State of Ohio
My Commission Expires
October 19, 2020

Office of Health Care Quality ...
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FOR OFFICE USE ONLY

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STATE01' MARYi.ANO

DHMH

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 \Vadc Avenue • Catonsvillc, Maryland 21228-4663
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R t:N t: \ V,\1, Arrt.lCATION rACKET
FOR COMPREHENSI VECARE & E XTENDED CARE FACILI TIES

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A. Applicnlion for Liccnsurc
Room ruul Bed Urcnkdown is n-quin:d n1 the time or license nc.wnl

8. Principal Physicinn Agn:cmcnt & Relief Physician Agn.. mcnt

C. Director of Nursing Agrt..-c:mcnl

D. Fucilily Om1cr.<hip (Medicaid i\ pplicution)[1]

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SECTION B- LONG TERM CI\RE PROVJOER AI'PLICATION

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(signature) 3/24/10

Relief Physician (signature) *Date*

Relief Physician Information (please type or print)

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StCTIONC- LO:-IGTERMCARE PROVIDERAPPLICATION

DIRECTOR OF NURSING AGREEMENT

Namr or Facllity: F ttoo.1h&Rohab **License #:** 215020

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DHMll 11SC-11,vbcd 3116/2010

MEDICAL CARE PR OGRAM • PAOVIDER APPLICATION

IMPORTA.kf: PI.EASE READ AfTACtiEDINS!RUC'nONS BEFORE COMPt.enNG APPI.ICA

1) APPUC'ATION TYPE:

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I am applying as a.... Please check one:

Requested Enrollment Begin Date

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2) PROVIDER INFORMATIOJii

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Group/Facility/Business/Agency Name		Fiscal Year End Date
Marlboro Leasing Co., LLC d/b/a Forestville Health & Rehabilitation Center		
Physician/Practitioner Last Name	First/Middle	
PDm:I md1 Chor'l!!!!iRstolb:		E-mail/Website Address
Primary Practice Address		Suite Number / Handicap Access
7420 Marlboro Pike		
City	S-	4,ICoi:111
Forestville	MO	20741
fdcpv;nl	Fax Number / County Code	Tr?ll
301-738--0l40,	301-736-1129 / 111	lo7-
Employer Identification Number	Name of EIN Owner	Social Security Number
	marlboro leasing Co.,LLC	

I) LICENSEIPERMff INFORMATION

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Name	Medicare Number
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SECTION D- Revised 3/16/2010

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6) SPECIALTYVERIFICATION

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7J GROUPMEMBI:RSHP INFORMATION

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11) AUTHORIZATION

I, the practitioner, administrator or authorized professional representative of this group, by affirm that this information given by me is true and complete to the best of my knowledge and belief. I understand that my group is subject to hospital or other institution for patient care that I or my group ; the Maryland Medical Care Program, those services for which D of 9 Up ssolariod.

Date 1,)Y>nYIO\\c,

YV' S'.,uo,

Charles R. Stoltz

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

N/A

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

PRACTITIONER fv¼Cr

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\.== Charles R. Stoltz

2 ba)llrtner

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Charles R. Stoltz, Ronald S. Wilheim, Isaac Rosedale

4. MS ocomtw\lttlonol $CCI andJndlrod p intcfostt oqu4l to5%o, moto In the Provid«

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parent + child

SECTION O

PROVIDER OWNERSHIP AND CONTROL DISCLOSURE FORM

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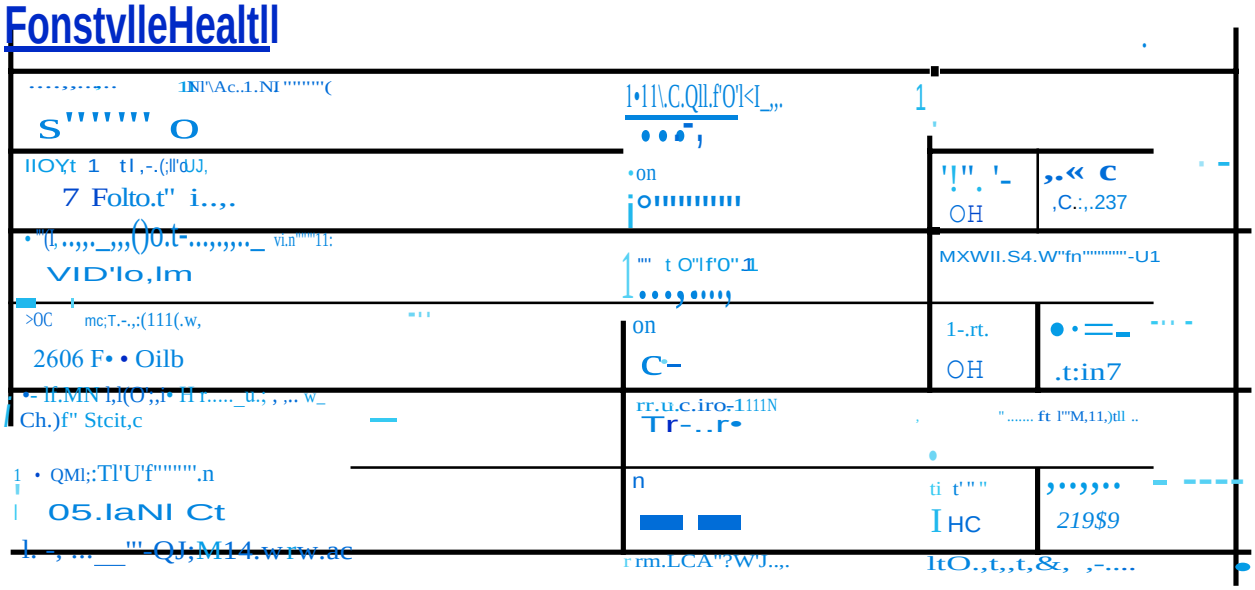

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NAME OF FACILITY:

Forestville Health & Rehabilitation Center

Signature of Authorized Official — CFO Title — 3/30/2016 Date

SECTION F -\YORKERS' COMPENSATION LA \V QUESTIONAIRE

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SECTION I : ADVERSE ACTIONS/CONVICTIONS

11lissection c-np1ures infomwtion on ad\'crse lcsal nc1ions. such os convic1ions.•exclusions, n!\'OCations. nnd suspensions. 1-\ll npplicabh:adverse lq;.itl oclions must ben:portcd. rcsardkssof whc1hcr nnv rcc.:ords \\'Crc ex un•cdor unv n • Isarc ndin..

ADVERSE ACTIONS THAT MUST BE REPORTED

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2. 1\ny misdemeanor conviction. under federal of Stutc low, related to:(n) thedcli\'CI)' of nn item or service under Mtdicnrc or a S tntc hcah h care program. or (b) theobusc or ncslei:t ofa patil!nl in connections with the dclivcl}' ofn health CLU'C item or Stt\'icc.
3. J\ny misdcmc.anorconviction, under FcdcmJ ofState law, related to theft. fmud. cmbc-,;,Jcmcnt.. breach of fiducial}' duty.or otherfin.onciul misconduct in connc;1;:tion with thedeliver)' ofa health care item or service.
4. An)' misdcmCMOr conviction. under fcdcrnl ofState law. n:llitcd to the intcrfrn:ncc with or obstruc1ion ofany investisntion into nny criminal offensedescribed in 42 C.F.R.Section 1001.101 or 1001.201.

S. Any misdcmconor con\'iction.under Fcdcml of Suite la\\'. related to 1hc unluwful monofocturc. distribution, prc:«:ription.or dispensing ofa controllod substoncc.

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I. Any rcvociuion or $USpc:nsion ofa license to providehealth cnrc bynny Str1tc licensingauthority. 'lll is includes thesurrender of such license while a fomu1Idisciplinary proceeding wns pending before n Stntc licensing authority.
2. Any rcvocntion of suspension of nceredi1u1ion.
3. Any suspension or exclusion from par1icip.11ionin. or nnys.·mcrion imposed by.a F<tleml or Stnlc hcallhcnn: prov-1m. or :my dcb.mncnt from par1icip;11ion in nny Fcdcml E.xccu1ivc Drnnch procurement or non..procun:rncnt program.
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SECTION I: ADVE RSE ACTIONS/CONVICT IONS (<ooliou rd)

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0 YES- Continue Below ☒ NO

2. If yes. reporteach adverse11ctio n when it occuncd. the 1:-cdcrntor Stutc ugcncy or the court/mlministrnt·ic, body that imposcdthe action. ond the resolution, if ony. Atmch o copy of the adverse action Jocwncnuuion nnd rcsohnion.

Adverse Actinn		Takrn lly	Rcrnludon

SECT ION J: CHA[N HOME OFF[CE [NFORM ATION

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Co mplc ce Sc-ctk1n **J** in full to identi fy the new c:hn.in home offie(:.

The name of provider's chain home office is changing (all other information remains the same). 2005

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N.mie of Hoo,c Offir:ic First Name Charles	Middle Name E	Last Name Stoltz	Jr., Sr., d♦
Title of Home Office Administrator CFO	Social Security Number [redacted]	Date of Birth (mm/dd/yyyy) [redacted]	

Healthcare Facility Management LLC

SECTION J: CE·I AIN HOME OFPJCE]NFORMAT!ON (cmrlimd)

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t.\1Ob A c d tlc.

Home Office Business Street Address Line 2 (Suite, Room, etc.)

Suite 200

City/Town Cincinnati | lnro | 7.11' C'oJ.c, .. q5:;J4'

Telephone Number [redacted] | Fn . Nl;l111 1,if ; -6\3 - - \o cr | E-mail Address (if applicable)

3. Home Office Tax Identification Number [redacted] | I [oIIIe OlfKC R(l10il'l Y •l:l!d lnliC'f- iJll lJ ol

4. Home Office Fee-For-Service Contractor | Home Office Chain Number [redacted]

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MARYLAND MEDICAL ASSISTANCE

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MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

OFFICE OF HEALTH CARE QUALITY

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No. 1 17

Issued to: Forestville Health & Rehabilitation Center
7420 Marlboro Pike
Forestville, MD 20747

Type of Facility and Number of Beds:
Comprehensive Care Facility • 152 Beds

Date Issued: April 19, 2014

This license is granted to: Marull>o<o "!I Co.'4£

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Expiration Date: April 19, 2016

Patricia Tomsko Nay

Director

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Legal Name	Facility d/b/a	Street	City, State, Zip	Phone	Fax	Type	Medicare #
outh Hl Leasing Co., LLC	Advanced Specialty Hospitals of Greenbriar Rehabilitation	8064 South Avenue, Suite 1	Boardman, OH 44512-6153	Ph: (330) 965-6432	Fax: (330) 965-6438	LTCH	360349
arden II Leasing Co., LLC	Advanced Specialty Hospital of Toledo (LTACH)	1015 Garden Lake Parkway	Toledo, OH 43614-2798	Ph (419) 381-0037	Fax (419) 381-3990	IRF	363032
ront Leasing Co., LLC	Aristocrat Berea Skilled Nursing & Rehab Ctr.	255 Front Street	Berea, OH 44017-1943	Ph (440) 243-4000	Fax (440) 234-0819	SNF/ICF	365608
kyline (PA) Leasing Co., LLC	Baldwin Health Center	3717 Skyline Drive	Pittsburgh, PA 15227-1744	Ph: (412) 885-8400	Fax: (412) 885-0772	SNF	395745
el Pre Leasing Co., LLC	Bel Pre Health & Rehab Center	2601 Bel Pre Road	Silver Spring, MD 20906-2313	Ph: (301) 598-6000	Fax: (301) 598-4678	SNF	215065
heldon Leasing Co., LLC	Berea Alzheimer's Care Center	49 Sheldon Road	Berea, OH 44017-1136	Ph: (440) 234-0454	Fax: (440) 234-0494	SNF	365893
iberty Leasing Co., LLC	BridgePark Healthcare Center	4017 Liberty Heights Avenue	Baltimore, MD 21207-7545	Ph: (410) 542-5306	Fax: (410) 664-1417	SNF	215195
oyce Leasing Co., LLC	BridgePort Healthcare Center	2125 Royce Street	Portsmouth, OH 45662-4714	Ph: (740) 354-6635	Fax: (740) 354-1443	SNF	365313
pringdale Leasing Co., LLC	Burlington House Rehab & Alz. Care Ctr.	2222 Springdale Road	Cincinnati, OH 45231-1805	Ph: (513) 851-7888	Fax: (513) 589-3444	SNF	365892
elmore Leasing Co., LLC	Candlewood Park Healthcare Center	1835 Belmore Road	East Cleveland, OH 44112-4301	Ph: (216) 268-3600	Fax: (216) 761-1322	SNF	365353
Vater Leasing Co., LLC	Chardon Healthcare Center	620 Water Street	Chardon, OH 44024-1149	Ph: (440) 285-9400	Fax: (440) 285-9378	SNF	365711
ity View Nursing & Rehab LLC	City View Nursing & Rehab Center	6606 Carnegie Avenue	Cleveland OH 44103-4622	Ph: (216)361-1414	Fax: (216) 361-2822	SNF	365879
Time Leasing Co., LLC	Columbus Healthcare Center	4301 Clime Road, North	Columbus, OH 43228-3403	Ph: (614) 276-4400	Fax: (614) 278-7645	SNF	365686
arden Leasing Co., LLC	CommuniCare at Waterford Commons	955 Garden Lake Parkway	Toledo, OH 43614-2793	Ph: (419) 382-2200	Fax: (419) 381-0188	SNF	365704
lifton Care Center Inc	CommuniCare of Clifton Postacute & Rehab Ctr.	625 Probasco Street	Cincinnati, OH 45220-2710	Ph: (513) 281-2464	Fax: (513) 281-2559	SNF	365304
eritage Leasing Co., LLC	Copley Health Center	155 Heritage Woods Drive	Copley, OH 44321-1398	Ph: (330) 666-0980	Fax: (330) 666-5585	SNF	365771
idland Leasing Co., LLC	Crestwood Care Center	225 West Main Street	Shelby, OH 44875-1412	Ph: (419) 347-1266	Fax: (419) 342-7035	SNF	365284
lo-GP Leasing Co., LLC	Crystal Creek Health & Rehab Center	250 New Florissant Road South	Florissant, MO 63031-6716	Ph: (314) 838-2211	Fax: (314) 838-5981	SNF	265607
idge (MD) Leasing Co., LLC	Ellicott City Health & Rehab Center	3000 North Ridge Road	Ellicott City, MD 21043-3311	Ph: (410) 461-7577	Fax: (410) 203-1897	SNF	215160
alling Leasing Co., LLC	Falling Water Healthcare Center	18840 Falling Water Road	Strongsville, OH 44136-4200	Ph: (440)238-1100	Fax: (440) 238-9575	SNF	366111
ayette Leasing Co., LLC	Fayette Health & Rehab Center	1217 West Fayette Street	Baltimore, MD 21223-1938	Ph: (410) 727-3947	Fax: (410) 385-5886	SNF	215183
Marlboro Leasing Co., LLC	Forestville Health & Rehab Center	7420 Marlboro Pike	Forestville, MD 20747-4343	Ph: (301) 736-0240	Fax: (301) 736-1129	SNF	215020
ivingston Leasing Co., LLC	Fort Washington Health & Rehab Ctr.	12021 Livingston Road	Ft. Washington, MD 20744-421	Ph: (301) 292-0300	Fax: (301) 292-2986	SNF	215146
Merit Leasing Co., LLC	Grande Pointe Healthcare Community	3 Merit Drive	Richmond Heights, OH 44143-1	Ph: (216) 261-9600	Fax: (216) 261-9662	SNF	366008
South I Leasing Co., LLC	Greenbriar North Healthcare Center	8064 South Avenue	Boardman, OH 44512-6153	Ph: (330) 726-3700	Fax: (330) 726-2194	SNF	365853
Pearl Leasing Co., LLC	Greenbrier Senior Living Community	6455 Pearl Road	Parma Heights, OH 44130-298	Ph: (440) 888-5900	Fax: (440) 888-0976	SNF	365192
Green Park Leasing Co., LLC	Green Park Senior Living Community	9350 Green Park Road	St. Louis, MO 63123-7211	Ph: (314) 845-0900	Fax: (314) 845-0901	SNF	265703
Avis Leasing Co., LLC	Hanover House Nursing & Rehab Ctr.	435 Avis Avenue NW	Massillon, OH 44646-3555	Ph: (330) 837-1741	Fax: (330) 837-1747	SNF	365292
Fairchild (MD) Leasing Co., LLC	Kent Healthcare Center	1290 Fairchild Avenue	Kent, OH 44240-1814	Ph: (330) 678-4912	Fax: (330) 678-1040	SNF	365834
Kolbe Leasing Co., LLC	Lake Pointe Health Center (OECC)	3364 Kolbe Road	Lorain, OH 44053-1628	Ph: (440) 282-2244	Fax: (440) 282-7709	SNF	365623
Howard Leasing Co., LLC	Marley Neck Health & Rehab Center	7575 East Howard Road	Glen Burnie, MD 21060-8312	Ph: (410) 768-8200	Fax: (410) 768-2954	SNF	215138
Rocky River Leasing Co., LLC	Northwestern Healthcare Center	570 North Rocky River Drive	Berea, OH 44017-1613	Ph: (440) 243-2122	Fax: (440) 243-4314	SNF	365811
East Water Leasing Co., LLC	Oak Grove Healthcare Center	620 East Water Street	Deshler, OH 43516-1327	Ph: (419) 278-6921	Fax: (419) 278-2910	SNF	365767
Jarvis Leasing Co., LLC	Pebble Creek	670 Jarvis Road	Akron, OH 44319-2538	Ph: (330) 645-0200	Fax: (330) 645-0316	SNF	365727
Brecksville Leasing Co., LLC	Pine Valley Care Center	4360 Brecksville Road	Richfield, OH 44286-9457	Ph: (330) 659-6166	Fax: (330) 659-2944	SNF	365370
Regency Leasing Co., LLC	Regency Manor Rehab & Subacute Ctr.	2000 Regency Manor Circle	Columbus, OH 43207-1777	Ph: (614) 445-8261	Fax: (614) 445-8050	SNF	365484
King Tree Leasing Co., LLC	Riverside Nursing & Rehab Center	1390 King Tree Drive	Dayton, OH 45405-1401	Ph: (937) 278-0723	Fax: (937) 278-1989	SNF	365877
Washington Leasing Co., LLC	South River Health & Rehab Center	144 Washington Road	Edgewater, MD 21037-1412	Ph: (410) 956-5000	Fax: (410) 956-0470	SNF	215297
Emery Leasing Co., LLC	Suburban Pavilion Nursing & Rehab Ctr.	20265 Emery Road	North Randall, OH 44128-4122	Ph: (216) 475-8880	Fax: (216) 587-4806	SNF	365215
Old Leasing Co., LLC	Wexford House Nursing & Rehab Ctr.	9850 Old Perry Highway	Wexford, PA 15090-9311	Ph: (412) 366-7900	Fax: (412) 366-8768	SNF	395300
Summitt (Ohio) Leasing Co., LLC	Wood Glen Alzheimer's Community	3800 Summit Glen Drive	Dayton, OH 45449-3647	Ph: (937) 436-2273	Fax: (937) 436-4771	SNF	365722
Wyant Leasing Co., LLC	Wyant Woods Care Center	200 Wyant Road	Akron, OH 44313-4228	Ph: (330) 836-7953	Fax: (330) 836-6806	SNF	365779

Exhibit B