FOIA Data Base - The Law Office of Jeffrey Downey Serving clients in Washington D.C., Virginia and Maryland
If you have been injured in a nursing home or assisted living facility, call the law office of Jeffrey J. Downey for a free consultation.

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

Heartfields at Bowie
7600 Laurel Bowie Road
Bowie, MD 20715

Facility Characteristics

- Nursing Facility with 52 Beds
- Date Facility First Opened: 1/2000
- http://www.fivestarseniorliving.com
- For Profit Corporation owned by Five Star Senior Living, Inc.
- Administrator – Aaron Campbell

Researching Nursing Homes

A note by attorney Jeffrey J. Downey:

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

The Maryland Department of Health's Office of Health Care Quality inspect assisted living facilities, including Heartfields at Bowie in Bowie MD. Periodically, they do inspections as complaint surveys which should be for public record. You can write to the following address:

Maryland Department of Health
Office of Health Care Quality
7120 Samuel Morse Drive
Second Floor
Columbia, MD 21046-3422

(https://health.maryland.gov/ohcq/docs/complaint_form.pdf)

You may also email AL.Help@maryland.gov or call (410) 402-8015
2) Fax : 410-402-8179
3) Online - https://fs30.formsite.com/OHCQ/OnlineComplaintForm/index.html

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

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

Office of Health Care Qualitv

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	()(3) DATE SURVEY COMPLETED
	AL002823	A. BUILDING: _____ B. WING	C 04/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
E 00	Initial Comments On 04/08/2020 an unannounced Administrative Review of a Self-reported Incident was conducted by a representative of the Office of Health Care Quality (OHCQ) to determine whether the immediate health and safety needs of the residents are being met and determining the compliance with COMAR 10.07.14, Assisted Living Program Regulations. Survey activities included: An Administrative Review of 1 resident record and telephone interviews with the ALM and DN. The facility's census at the time of the survey was fifty (50) **residents.** Based on survey findings, in relation only to intake number MD00152919, the following deficiencies were identified on the date of the investigation. Acronyms which may appear in this report are defined as follows: ALM: Assisted Living Manager, AALM: Alternate Assisted Living Manager, CMT: Certified Medication Technician, CDS: Controlled Dangerous Substance, DN: Delegating Nurse, FA: Manager' s Functional Assessment, HCPPA: Health Care Practitioner's Physical **Assessment,** MAR: Medication Administration Record, RAT: Resident Assessment Tool, SP: Service Plan	E 000		
E2320	.15 C2(e)-(g) .15 Assisted Living Manager (e) Providing or ensuring, through the **coordination of community services, that each** resident has access to appropriate medical and	E2320		

OHCQ

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

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA JDENTJFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	()(3) DATE SURVEY COMPLETED
	AL002823	A. BUILDING: _____ B. \AJING	C 04/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	1)(5) COMPLETE DATE
E2320	Continued From page 1 psychosocial services, as established in the resident service plan developed under Regulation .26 of this chapter; (I) Ensuring that there is appropriate coordination of all components of a resident's service plan, including necessary transportation and delivery of needed supplies; (g) Ensuring that there is appropriate oversight and monitoring of the implementation of each resident's service plan; This REQUIREMENT is not met as evidenced by: Based on an Administrative Review of records and interview of the ALM and ON on 04/08/2020, it was determined the facility failed to ensure that there was appropriate oversight and monitoring of the implementation of each resident's service plan. Findings include: An Administrative Review of records on 04/08/2020 revealed Resident #1 sustained 4 falls in March, 2020, There were no fall **prevention interventions documented on the** service plan. Resident #1 was on a high-risk medication, blood thinner, and there were no interventions on the service plan in regard to the high risk medication. During a telephone interview of the ON and ALM on 04/08/2020 revealed the "service plan was **missed."**	E2320	E232O BY 4/15/20 ON will ensure each resident's service plan has been updated. Effective immediately ON will ensure within 24 hours of new admissions, re-admission, hospitalization or change in condition a new or existing Service Plan will be completed. BY 4/30/20 DON will audit all Service Plans. BY 5/1/20 DON and ED will perform bi- monthly checks to ensure this deficiency does not reoccur. Resident Service Plans will be reviewed during quarterly QA meetings to ensure accuracy.	
E2780	.20 C .20 Delegating Nurse **C.** Duties. The delegating nurse shall:	E2780		

Office of Health Care Qualit"

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HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

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E2780	Continued From page 2 (1) Be on-site to observe each resident at least every 45 days; (2) Be available on call as required under this chapter or have a qualified alternate delegating nurse available on call; and (3) Have the overall responsibility for: (a) Managing the clinical oversight of resident care in the assisted living program; (b) Issuing nursing or clinical orders, based upon the needs of residents; (c) Reviewing the assisted living manager's **assessment of residents;** (d) Appropriate delegation of nursing tasks; and (e) Notifying the OHCQ: (i) If the delegating nurse's contract or employment with the assisted living program is terminated; and (ii) Of the reason why the contract or employment **was terminated.** This REQUIREMENT is not met as evidenced by: **Based on an Administrative Review of records** and telephone interview of the ALM and DN on 04/08/2020, it was determined the facility failed to ensure the delegating nurse maintained clinical **oversight of resident care in assisted living.** Findings include: **An Administrative Review of records, on** 04/08/2020 revealed Resident #1 sustained 4 falls in March 2020, The delegating nurse failed to ensure there were progressive fall prevention interventions documented on the service plan. Resident #1 was on a high-risk medication, blood thinner, and there were no interventions on the service plan in regard to the high-risk medication.	E2780	E2780 By 4/15/20 DN will ensure each resident's service plan will be updated within 24 hours of new admissions, re-admission, hospitalization or change in condition. Effective 4/30/20 DN will audit all Service Plans. BY 5/1/20 DN and ED will perform bi- monthly checks to ensure to ensure deficiency does not reoccur and to ensure they receive the correct medication, treatment and the service is adequate and appropriate per individual. Resident Service Plans will be reviewed during quarterly QA meetings to ensure accuracy.	

Office of Health Care Quality

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E2780	Continued From page 3 During a telephone interview of the ON and ALM on 04/08/2020 revealed the "service plan was missed."	E2780		
E3330	.26 B1,2 .26 Service Plan B. Assessment of Condition. (1) The resident's service plan shall be based on assessments of the resident's health, function, and psychosocial status using the Resident Assessment Tool. (2) A full assessment of the resident shall be completed: (a) Within 48 hours but not later than required by nursing practice and the patient's condition after: (i) A significant change of condition; and (ii) Each nonroutine hospitalization; and (b) At least annually. This REQUIREMENT is not met as evidenced by: Based on an Administrative Review of records and telephone interview of the ALM, ON on 04/08/2020, it was determined the facility failed to ensure the resident's service plan was based on assessments of the resident's health, function, and psychosocial status. Findings include: An Administrative review of records on 04/08/2020 for Resident #1 revealed Resident #1 was placed on a high risk medication, blood thinner, on 02/27/2020 The Service Plan was completed on 05/10/2019 and updated on 03/29/2020 and 03/31/2020 and did not include interventions related to these high risk	E3330	E3330 By 4/15/20 DN will ensure each resident's service plan will be updated within 24 hours of new admissions, re-admission, hospitalization or change in condition a new or existing Service Plan will be completed. By 4/30/20 DN will audit all Service Plans. By 5/1/20 DN and ED will perform bi- monthly checks to ensure deficiency does not reoccur and to ensure they receive the correct medication, treatment and the service is adequate and appropriate per individual. Resident Service Plans will be reviewed during quarterly QA meetings to ensure accuracy.	

Office of Health Care Qualit"

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	AL002823	A. BUILDING: _____ B. WING	C 04/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

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E3330	Continued From page 4 **medications.** An Administrative Review of records on 04/08/2020 for Resident #1 revealed Resident #1 sustained falls on 4 occasions in 03/2020. The Service Plan was completed on 05/10/2019 and updated on 03/29/2020 and 03/31/2020 and there were no interventions for fall prevention. Fall Risk Assessments were completed on 4 dates in March, 2020 with scores which documented Resident #1 was at high risk for falls. During a telephone interview of the ALM, and DN and 04/06/2020 revealed the ALM and DN stated, **"It was missed."**	E3330		
E3960	.35 A1,2 .35 Resident's Rights .35 Resident's Rights. A. A resident of an assisted living program has the right to: (1) Be treated with consideration, respect, and full recognition of the resident's human dignity and individuality; (2) Receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant State, local, and federal laws and regulations; This REQUIREMENT is not met as evidenced by: Based upon Administrative Review and telephone interview of the ALM and DN on 04/.08/2020, it was determined the facility failed to ensure the **residents receive treatment, care and services** that are adequate and appropriate. Findings include:	E3960	E3960 BY 4/15/20 DN will ensure each resident's service plan has been update updated within 24 hours of new admissions, re-admission, hospitalization or change in condition a new or existing Service Plan will be completed. BY 4/30/20 DN will audit all Service Plans. 5/1/20 DN and ED will perform bi- monthly checks to ensure this deficiency does not reoccur and to ensure they receive the correct medication, treatment and the service is adequate and appropriate per individual. , Resident Service Plans will be reviewed during quarterly QA meetings to ensure accuracy.	

Office of Health Care Quality

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	AL002823	A. BUILDING: _____ B. VIJING	C 04/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

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E3330	Continued From page 4 medications. An Administrative Review of records on 04/08/2020 for Resident #1 revealed Resident #1 sustained falls on 4 occasions in 03/2020. The Service Plan was completed on 05/10/2019 and updated on 03/29/2020 and 03/31/2020 and there were no interventions for fall prevention. Fall Risk Assessments were completed on 4 dates in March, 2020 with scores which documented Resident #1 was at high risk for falls. During a telephone interview of the ALM, and ON and 04/06/2020 revealed the ALM and ON stated, "It was missed."	E3330		
E3960	.35 A1,2 .35 Resident's Rights .35 Resident's Rights. A. A resident of an assisted living program has the right to: (1) Be treated with consideration, respect, and full recognition of the resident's human dignity and individuality; (2) Receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant State, local, and federal laws and regulations; This REQUIREMENT is not met as evidenced by: Based upon Administrative Review and telephone interview of the ALM and ON on 04/.08/2020, it was determined the facility failed to ensure the residents receive treatment, care and services that are adequate and appropriate. Findings include:	E3960		

Office of Health Care Qualitv

STATEMENT OF DEFICIENCIES AND PIAN OF CORRECTION	{X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	{X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL002823	A. BUILDING:_____ B. vVING	C 04/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD **BOWIE, MD 20715**

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E3960	Continued From page 5 An Administrative Review of records on 04/08/2020 revealed Resident #1 sustained 4 falls in March, 2020, There were no fall prevention interventions documented on the service plan to prevent or mitigate Resident #1's injuries from falls. Resident #1 was on a high risk medication, blood thinner, and there were no interventions on the service plan in regard to the high risk medication. During a telephone interview of the DN and ALM on 04/08/2020 revealed the "service plan was missed." ALM stated Resident #1 had not been referred to physical therapy after the initial or subsequent falls.	E3960		

Office of Health Care Quality

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	16AL492	A. BUILDING: _____ B. WING _____	C 03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	**7600 LAUREL BOWIE ROAD BOWIE, MD 20715**

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E 000	Initial Comments On March 3, 2020 an unannounced survey for a self-reported incident was made to the above named facility for the purpose of determining the facility's compliance with COMAR 10.07.14, Assisted Living Regulations. Survey activities included observation of the facility, staff interviews and review of one resident record. Based on the survey findings, in relation only to intake #MD00149255, the facility was found to comply with the regulations governing Assisted Living Programs, COMAR 10.07.14. The facility's census at the time of the survey was 52 residents.	E 000		

OHCQ

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

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING: _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

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E 000	Initial Comments On 09/20/2019, an unannounced visit was made to the above named facility in response to a self-reported incident, for the purpose of determining the facility's compliance with COMAR 10.7.14, Assisted Living Programs. Survey activities included an interview with the Executive Director (ED), review of 1 resident record, 2 staff records, and the facility's records. Based on survey findings, in relation only to self-report # MD00142716, the following deficiencies were identified on the date of the investigation.	E 000		
E4000	.35 A7,8 .35 Resident's Rights (7) Be free from mental, verbal, sexual, and physical abuse, neglect, involuntary seclusion, and exploitation; (8) Be free from physical and chemical restraints; This REQUIREMENT is not met as evidenced by: Based an interview with the Executive Director (ED), review of 1 resident record, 2 staff records, and the facility's records, the facility failed to protect the resident's right to be free from mental, verbal, and physical abuse. Findings Include: An interview with the Executive Director (ED), review of 1 resident record, 2 staff records, and the facility's records, revealed that on 07/08/19, staff #1 witnessed staff #2 hit/struck resident #1 on the right forearm and hand.	E4000		
E4180	.36 C1 .36 Abuse, Neglect, & Financial Exploitation	E4180		

OHCQ

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING: _____ B. WING _____	C 09/20/2019

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E4180	Continued From page 1 C. Reports of Abuse, Neglect, or Financial Exploitation. (1) A licensee or employee of an assisted living program who has witnessed, or otherwise has reason to believe, that a resident has been subjected to abuse, neglect, or financial exploitation shall report the alleged abuse, neglect, or exploitation within 24 hours to: (a) The appropriate local department of social services, Adult Protective Services Program; and (b) One or more of the following: (i) A local law enforcement agency; (ii) The Office of Health Care Quality of the Department; (iii) A representative of the Long-Term Care Ombudsman Program in the Department of Aging or local area agency on aging. This REQUIREMENT is not met as evidenced by: Based on an interview with the Executive Director (ED), review of 1 resident record, 2 staff records, and the facility's records, Staff #1 failed to report the abuse of 2 residents within 24 hours of having knowledge of the alleged abuse. Findings Include: an interview with the Executive Director (ED), review of 1 resident record, 2 staff records, and the facility's record, revealed that on 07/08/19, staff #1 witnessed staff #2 hit/struck resident #1 on the right forearm and hand but failed to report the abuse within 24 hours. Staff #1 reported the abuse to the Director of Nursing (DON) on 07/15/19. The ED stated that staff #1 stated in an interview that the abuse was not reported in a timely manner because staff #1 thought Staff #2 would report the abuse.	E4180		

Office of Health Care Quality

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIERIC LIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING:_____ B. WING_____	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

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E 000	**Initial Comments** On 07-09-2019 and 07-10-2019 an unannounced Inspection of Care (IOC) survey was conducted by a representative of the Office of Health Care Quality for the purpose of determining the facility's compliance with the requirements of COMAR 10.07.14, for Assisted Living Programs. Survey activities included a tour of the facility, observation of the environment, interviews with staff and residents, and review of administrative, staffing, and resident records. Based on survey findings, the following deficiencies were identified on the date of the investigation. The facility's census on the date of survey was 51 residents. Acronyms which may appear in this report are defined as follows: ALM- Assisted Living Manager AALM- Alternate Assisted Living Manager **ON**- Delegating Nurse	E 000		
E3330	.26 81,2 .26 Service Plan 8. Assessment of Condition. (1) The resident's service plan shall be based on assessments of the resident's health, function, and psychosocial status using the Resident Assessment Tool. (2) A full assessment of the resident shall be completed: (a) Within 48 hours but not later than required by nursing practice and the patient's condition after: (i) A significant change of condition; and (ii) Each nonroutine hospitalization; and (b) At least annually. This REQUIREMENT is not met as evidenced	E3330		

OHCQ
LABORATORYDIRECTOR'SORPROVIDER/SUPPLIERREPRESENTATIVE'SSIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFI CATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING:_____ B. WING_____	07/10/2019

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E3330	Continued From page 1 by: Based on interview with *staff* and review of re cords, the facility failed to ensure a full assessment was completed within 48 hours after a resident had a significant change in condition and nonroutine hospitalization. This was true for 3 of 5 residents. Findings Include: On 07-10-2019 review of resident records and resident Incident Reports revealed Resident #1 was transported to a hospital emergency room during – 2019 and – 2019; Resident #2 was transported to an emergency room during – 2019; and Resident #5 was transported to an emergency room during - 2019 however, there was no evidence that a full assessment was completed for each resident within 48 hours after return back to the facility. On 07-10-2019 interview with the DN revealed a nursing note was enter for the aforementioned incidents however, a full assessment was not completed. This was also confirmed with the **ALM .**	E3330		
E 4630	.41 A .41 General Physical Plant Requirements .41 General Physical Plant Requirements. A. The facility, which includes buildings, common are as, and exterior grounds, shall be kept: (1) In good repair; (2) Clean; (3) Free of any object, material, or condition that may create a health hazard, accident, or fire; (4) Free of any object, material, or condition that may create a public nuisance; and (5) Free of insects and rodents.	E4630		

Office of Health Care Quality

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E4630	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation during a tour of the facility and interview with staff, the facility failed to ensure all resident rooms were kept clean as required. This was true for 1 of 4 resident rooms. Findings Include: On 07-10-2019 observation during a tour of the facility with the ALM revealed 1 resident room with a private bathroom to have unclean floors and multiple dead bugs on the sink. On 07-10-2019 interview with the ALM revealed no awareness as to why the resident bathroom was found in the aforementioned condition. The ALM was observed instructing staff to clean the resident's bathroom on the date of survey.	E4630		
E4710	.44 A .44 Security .44 Security. A. The facility shall provide: (1) Exterior lockable doors and windows; and (2) An effective automated device or system to alert staff to individuals entering or leaving the building. This REQUIREMENT is not met as evidenced by: Based on observation during a tour of the facility and interview with staff, the facility failed to maintain operable alarming devices on the facility's exterior doors to alert staff to individuals entering or leaving the building. Findings Include:	E4710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING _____ B. WING _____	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E4710	Continued From page 3 On 07-10-2019 observation during a tour of the facility with the ALM revealed an unlocked door labeled Staff Only. Upon entering the unlocked Staff Only door observation revealed an unalarmed exterior exit door leading to an outdoor parking lot which would not have alerted staff to individuals exiting the building . On 07-10-2019 interview with the ALM revealed that the Staff Only door should have been locked and residents should not have been able to access the area beyond the labeled Staff Only door.	E4710		
E4910	.46 E3 .46 Emergency Preparedness (3) Semiannual Disaster Drill. (a) The assisted living program shall conduct a semiannual emergency and disaster drill on all shifts during which it practices evacuating residents or sheltering in-place so that each is practiced at least one time a year. (b) The drills may be conducted via a table-top exercise if the program can demonstrate that moving residents will be harmful to the residents. (c) Documentation. The assisted living program shall: (i) Document completion of each disaster drill or training session; (ii) Have all staff who participated in the drill or training sign the document; (iii) Document any opportunities for improvement as identified as a result of the drill; and (iv) Keep the documentation on file for a minimum of 2 years.	E4910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING:_____ B. VvlNG _____	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS , CITY, STATE,ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEDBY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COM PLE TE DATE
E4910	E4910 Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview with staff and review of records, the facility failed to provide evidence that disaster drills were completed semiannually, on all shifts as required. Findings include: On 07-09-2019 and 07-10-2019 review of the facility's disaster drills revealed no evidence that a disaster drill had been completed since late-September 2018. On 07-10-2019 interview with the ALM revealed a disaster drill was recently conducted at the facility however, no documentation of the completed drill could be provided.	E4910		

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING _____ B. IMNG _____	C 07/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 000	E 000 Initial Comments On 07/10/2017, a complaint investigation , MDOO11513O was conducted at the above named facility. Survey activities included, interviews with Executive and Resident Services Directors, review of selected administrative and resident records. **No** deficient practice was identified specific to this allegation. The census on the Assisted Living Unit at the time of the alleged event was thirteen (13) residents.	E 000		

OHCQ

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

Office of Health Care Quality

STATEMENTOF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BU I L DING: _____ B. V'v1NG _____	C 06/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC TION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE D ATE
E OOO!	Initial Comments On 06/04/19, an unannounced visit was made to the above named facility to follow up on a self-reported incident Survey activities included an interview with the Assisted Living Manager (ALM), the Delegating Nursing (DN), and a review of 1 resident record including incident report and hospital discharge record. Based on survey findings, in relation only to self-report# MD00138045, the facility was found to be in compliance with the regulations governing Assisted Living facilities, COMAR 10.07 .14.	E 000		

OHCQ

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

Office of Health Care Qua itv

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFI CATION NUMBER:	(X2) MULTIPLE CON STRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A BUILDING:_____ B. VVING _____	C 02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRE SS, CITY. STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEDBY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TOTHE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
	E 000 Init ial Comments On 02/12/19, an unannounced visit was made to the above named facility to follow up on a self-reported incident. Survey activities included an interview with the Assisted Living Manager (ALM) , the Delegating Nursing (DN), and a review of 1 resident record including incident report and hospital discharge record. Based on survey findings, in relation only to self-report# MD00135178, the facility was found to be in compliance with the regulations governing Assisted Living facilities, COMAR 10.07.14.	E 000		

OHCQ

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

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING: _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

Office of Health Care Quality

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	16AL492	A. BUILDING: _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 000	Initial Comments On 09/20/19, an unannounced visit was made to the above named facility to follow up on a self-reported incident. Survey activities included an interview with the Assisted Living Manager (ALM), review of 1 resident record including incident report. Based on survey findings, in relation only to self-report # MD00144222, the facility was found to be in compliance with the regulations governing Assisted Living facilities, COMAR 10.07.14.	E 000		

OHCQ

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

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING:_____ B. WING_____	C 12/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
E 000	Initial Comments On 12/13/2018, an unannounced visit was made to the above named facility in response to 2 , self-reported incidents, for the purpose of determining the facility's compliance with COMAR 10.7.14, Assisted Living Programs. Survey activities included interviews with the Director of Nursing (DON), the Executive Director : (ED), staff #4, an unsuccessful attempt to interview with 2 residents, review of 2 resident records, 2 staff records, the facility's records, the police report, observation of 2 residents, and listening to the recording provided by staff #1. Based on survey findings, in relation only to self-report# MD00133754, MD00133940, and · MD00134733, the following deficiencies were · identified on the date of the investigation.	E 000		
E4000	.35 A7,8 .35 Resident's Rights (7) Be free from mental, verbal, sexual, and physical abuse, neglect, involuntary seclusion, . and exploitation; . (8) Be free from physical and chemical restraints; This REQUIREMENT is not met as evidenced by: Based on interviews with the Director of Nursing (DON), the Executive Director (ED), staff #4, review of 2 resident records, the facility's records, the police report, and listening to the recording provided by staff #1, the facility failed to protect the resident's right to be free from mental, verbal, and physical abuse. Findings Include: Interviews with the Director of Nursing (DON), the Executive Director (ED), staff #4, review of 2 resident records, the facility's	E4000		

OHCQ

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

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING:_____ B. Vv1NG_____	C 12/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
E4000	Continued From page 1 records, the police report, and listening to the recording provided by staff #1, revealed that staff , #2 claimed to have punched resident #1 so hard and the resident fell to the floor. Staff #2 also claimed to have punched and slapped resident #2 multiple times until the resident fell back on the bed. Staff #2 claimed to have assaulted residents #1 to staff #1 on 11/08/18 and both residents #1 and #2 on a recorded phone conversation on 11/11/18. The ED and DON confirmed these findings.	E4000		
E4180	.36 C1 .36 Abuse, Neglect, & Financial Exploitation C. Reports of Abuse, Neglect, or Financial Exploitation. (1) A licensee or employee of an assisted living program who has witnessed, or otherwise has reason to believe, that a resident has been , subjected to abuse, neglect, or financial , exploitation shall report the alleged abuse, neglect, or exploitation within 24 hours to: (a) The appropriate local department of social services, Adult Protective Services Program; and (b) One or more of the following: (i) A local law enforcement agency; (ii) The Office of Health Care Quality of the Department; (iii) A representative of the Long-Term Care Ombudsman Program in the Department of Aging or local area agency on aging. This REQUIREMENT is not met as evidenced by: Based on interviews with the Director of Nursing (DON), the Executive Director (ED), staff #4, review of 2 resident records, the facility's records, the police report, and listening to the recording	E4180		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CU A IDENTIFI CATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING:_____ B. WING _____	C 12/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIPCODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSCIDENTIFYIN G INF ORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEDTO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	E4180 Continued From page 2	E4180		

provided by *staff* #1, *Staff* #1 failed to report the abuse of 2 residents within 24 hours of having knowledge of the alleged abuse.

Findings Include: Interviews with the Director of Nursing (DON), the Executive Director (ED), *staff* #4, review of 2 resident records, the facility's records , the police report, and listening to the recording provided by *staff* #1, revealed that *staff* #2 claimed to have punched and slapped resident #2 multiple times and left hand prints on the resident's leg. *Staff* #1 revealed in an investigation interview that *staff* #1 observed hand prints on the resident #2's leg. *Staff* #2 claimed to have punched and slapped resident #1 and resident #2 on a recorded phone conversation with *staff* #1 on 11/11/18. *Staff* #1 failed to report the evidence and knowledge of abuse until 11/26/18. The ED and DON confirmed these findings.

Office of Health Care Qualitv

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUI DIN G _____ B. WNG _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACHCORRECTIVE ACTION SHOULD BE CROSS-REFERENCEDTOTHEAPPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
E OOOi	Initial Comments On 7/13/18, an unannounced investigation survey was made to the above named facility regarding a self-reported incident for the purpose of determining the facility's compliance with COMAR 10.07.14, Assisted Living Regulations .Survey activities included review of a resident record and facility documentation, interviews, and observation of the environment. Based on survey finding s, in relation to complaint MD00127484 only, the following deficiencies were identified on the date of the investigation. The facility's census at the time of the survey was 51 residents.	E 000		
E2280	.15 C1,2(a)-(c) .15 Assisted Living Manager C. Duties . The assisted living manager shall: (1) Be on-site or available on call; and (2) Have overall responsibility for: (a) The management of the assisted living program, including recruiting, hiring, training, and supervising all staff, and ensuring that either a criminal history records check or a criminal background check is conducted consistent with the requirements of Health-General Article, Title 19, Subtitle 19, Annotated Code of Maryland; (b) The development and implementation of a staffing plan, which includes an orientation and ongoing training program for all staff, with specific training in the management, assessment, and programming for the resident with cognitive impairment as required by Health-General Article, §19-319.1 , Annotated Code of Maryland; (c) The development and implementation of all policies, programs, and services as required by this chapter;	E2280		

OHCQ
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X 6) DATE

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFI CATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	16AL492	A BUILDING:_____ B. VvlNG_____	C 07/13/2018

NAME OF PROVIOEROR SUPPLIER	STREET ADDRE SS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEDBY FULL REGUL ATORY OR LSC IDENTIFYIN G INFORM ATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVEACTION SHOULDBE CROSS-REFERENCEDTO THE APPROPRIATE DEFICIENCY)	co C m D ATE
E2280	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of the resident record, facility documentation, and interview, the Executive Director (ED) failed to perform required duties involving policy. Findings included: On 7/13/18, a review of facility documentation revealed the facility elopement policy was not followed. Policy stated that police were to be contacted within 15 minutes from the time a resident was noted missing. However, police were not contacted until 20 minutes after Resident #1 was noted missing according to the resident record. This was confirmed in an interview with the ED on 7/13/18.	E2280		
E33ao	C3 .26 Service Plan (3) The service plan is reviewed by staff at least every 6 months, and updated, if needed, unless a resident's condition or preferences significantly change , in which case the assisted living manager or designee shall review and update the service plan sooner to respond to these changes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, facility staff failed to review the service plan every six months. This was true for 1 of 1 resident record reviewed . Findings included: On 7/13/18, review of the resident record for Resident #1 revealed there were two service	E3380		

STATEMENTOF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFIC ATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING:_____ B. IMNG_____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS . CITY, STATE. ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENC Y MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE D ATE
E3380	Continued From page 2 plans . One was dated for late November 2016 with no signatures (for the delegating nurse or the assisted living manager) or dates indicating that the service plan was reviewed at six-month intervals. This service plan was kept in the resident's chart. The other service plan was dated for mid-July 2016. It was signed as reviewed by the delegating nurse only (and not the assisted living manager) for the following dates: early September 2017, mid-October 2017, early March 2018, and mid-June 2018. The mid-July 2016 service plan was kept in a book. Neither of these service plans (the late November 2016 one nor the mid-July 2016 one) were reviewed by the delegating nurse (DN) and the assisted living manager (ALM) every six months. This was confirmed in an interview with the assisted living manager (ALM) on 7/13/18.	E3380		
E3420	.27 D .27 Resident Record or Log D. Resident Care Notes. (1) Appropriate staff shall write care notes for each resident: (a) On admission and at least weekly; (b) With any significant changes in the resident's condition, including when incidents occur and any follow-up action is taken; (c) When the resident is transferred from the facility to another skilled facility; (d) On return from medical appointments and when seen in home by any health care provider; (e) On return from nonroutine leaves of absence; and (f) 1/Vhen the resident is discharged permanently from the facility, including the location and manner of discharge. (2) Staff shall write care notes that are	E3420		

STATEMENT OF DEFI CIENCIE S AND PLAN OF CORRECTION	(X1) PROVIDER /SUPPLIER/CU A IDENTI FICATION NUMBER :	(X2) MULTIPLE CONSTRUC TION	(X3) DATE SURVE Y COMPLETED
	16AL492	A. BUILDING : _____ 8. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS , CIT Y, STATE, ZIPCODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMAR Y STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRE CEDED BYFULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID P REFIX TAG	PROVIDER 'S PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI ATE DEFICIENCY)	(XS) C OMPLET E DATE
E3420	E3420 Continued From page 3 individualized , legible, chronological, and signed by the writer. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete a care note that included the resident's permanent discharge from the facility . This was true for 1 of 1 resident record reviewed. Findings included: On 7/13/18, review of the record for Resident #1 revealed no care note was present to address the resident's permanent discharge from the facility in - 2018. This was confirmed in an interview with the Executive Director (ED) 7/13/18.			
E4710	E4710 .44 A .44 Security , .44 Security. A. The facility shall provide: (1) Exterior lockable doors and windows; and , (2) An effective automated device or system to alert staff to individuals entering or leaving the building. This REQUIREMENT is not met as evidenced by: Based on observation of the facility and interview, the facility failed to maintain an effective automated device or system to alert staff to individuals leaving the perimeter fence of the building's courtyard. Findings include: During a tour of the facility on 7/13/18,			

STATEMENT OF DEFI CIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTR UCTI ON	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING:_____ B. WING_____	C 07/13/2018

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	E4710 Continued From page 4	E4710		

observation revealed that new sensors were placed to a courtyard gate in response to a previous breach in the monitoring system that secured the outdoor courtyard of the memory care unit. This caused the gate to not remain secure. Resident #1 was able to exit via this gate in early June 2018. This was confirmed in an interview with the Executive Director (ED) on 7/13/18.

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	16AL492	A. BUILDING _____ B. WING _____	02/20/2018

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HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 000	Initial Comments On February 20, 2018 an Inspection of Care survey was conducted by representatives of the Office of Health Care Quality (OHCQ) to determine whether the immediate health and safety needs of the residents are being met and determining compliance with COMAR regulations 10.07.14, Assisted Living Program Regulations. Survey activities included a review of selected administrative, staff and residents' files, interview with staff and residents, observations, and a tour of the facility. The facility census at the time of the survey was forty nine (49) residents. Acronyms which may appear in this report are defined as follows: ALM - Assisted Living Manager; AALM - Alternate Assisted Living Manager; DN - Delegating Nurse; HCPPA - Health Care Practitioner's Physical Assessment; ALM FA - Assisted Living Manager Functional Assessment; LOC - Level of Care Scoring Tool; RAT- Resident Assessment Tool; and MAR - Medication Administration Record.	E 000		
E1880	.11 B .11 Investigation by Department B. Records and Reports. (1) Inspection. (a) A licensee shall maintain records and make reports as required by the Department. The records and reports shall be open to inspection by the Department or its designee. (b) Except for the records permitted to be stored off-site, a licensee or licensee's designee shall	E1880		

OHCQ

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

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING _____ B. WING _____	02/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

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E1880	Continued From page 1 immediately, upon request, provide copies of records and reports, including medical records of residents, to the Department or its designee. The Department or its designee shall, if requested, reimburse the licensee for the cost of copying the records and reports. (2) Maintenance. (a) The assisted living program shall maintain files on-site pertaining to: (i) Current residents; (ii) Residents who have been discharged within the last 6 months; (iii) Staff; and (iv) Quality assurance activities. (b) These files listed in §B(2)(a) of this regulation shall be maintained on-site where residents are being cared for. (c) All other records may be stored off-site , but shall be available for inspection within 24 hours of the Department's request or request of the Department's designee. This REQUIREMENT is not met as evidenced by. Based on observation, interview and record review on 2/20/18, it was determined that the facility failed to maintain a staff record on site as required. This was true for one of the eight staff records requested. Failure to maintain staff records may place residents at risk. Findings include: Observation of the facility records on 2/20/18 failed to reveal a staff record for the AALM . This staff record was asked for and could not be provided. Interview with the ALM revealed that this record is stored "at Corporate" .	E1880		

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E2600	Continued From page 2	E2600		
E26D0	.19 86, 7 .19 Other Staff--Qualifications	E2600		

(6) Receive initial and annual training in:
(a) Fire and life safety, including the use of fire extinguishers ;
(b) Infection control, including standard precautions , contact precautions, and hand hygiene;
(c) Basic food safety;
(d) Emergency disaster plans; and
(e) Basic first aid by a certified first aid instructor;
(7) Have training or experience in:
(a) The health and psychosocial needs of the population being served as appropriate to their job responsibilities;
(b) The resident assessment process;
(c) The use of service plans; and
(d) Resident's rights; and

This REQUIREMENT is not met as evidenced by:
Based on interview and record review on 2/20/18, it was determined that the facility failed to provide annual training/certification as required. This was true for six of the six relevant staff records reviewed. Failure to provide training/certification may place residents at risk.

Findings include:
Interview with facility staff and staff record review on 2/20/18 revealed:
- 2 of the 6 relevant staff did not have current documented certification in Basic First Aid;
- 5 of the 6 relevant staff did not have current documented training in Fire and Life Safety;
- 3 of the 3 relevant staff did not have current documented training in Infection Control;
- 5 of the 5 relevant staff did not have current documented training in Basic Food Safety; and

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E2600	Continued From page 3 - 6 of the 6 relevant staff did not have current documented training in Emergency Preparedness . These documents were asked for and could not be provided.	E2600		
E2730	.19 G4 .19 Other Staff--Quali fications (4) Ongoing training in cognitive impairment and mental illness shall be provided annually consisting of, at a minimum: (a) 2 hours for employees whose job duties involve the provision of personal care services as des c ribed in Regulation .2BD of this chapter; and (b) 1 hour for employees whose job duties do not involve the provision of personal care services as described in Regulation .2BD of this chapter. This REQUIREMENT is not met as evidenced by : Based on interview and record review on 2/20/18, it was determined that the facility failed to provide training as required. This was true for five of the e ight staff records reviewed. Failure to provide training annually may place residents at risk. Findings include: Interview with facility staff and review of staff records on 2/20/18 revealed no current documented training in Cognitive Impairment and Mental Illness for five of the eight staff records .	E2730		
E2780	.20 C .20 Delegating Nurse C. Duties . The delegating nurse shall: (1) Be on-site to observe each resident at least every 45 days; (2) Be available on call as required under this chapter or have a qualified alternate delegating	E2780		

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E2780	E2780 Continued From page 4 nurse available on call; and (3) Have the overall responsibility for: (a) Managing the clinical oversight of resident care in the assisted living program; (b) Issuing nursing or clinical orders, based upon the needs of residents; (c) Reviewing the assisted living manager's assessment of residents; (d) Appropriate delegation of nursing tasks; and (e) Notifying the OHCQ: (i) If the delegating nurse's contract or employment with the assisted living program is terminated; and (ii) Of the reason why the contract or employment was terminated. This REQUIREMENT is not met as evidenced by: Based on interview and record review on 2/20/18, it was determined that the ON failed to manage the clinical oversight of resident care as required. Failure to manage the clinical oversight may place residents at risk. Findings include: Review of records on 2/20/18 revealed that Resident #1 was admitted to the facility in- Further review revea led no ON Initial Assessment. Interview with the ON and the **ALM** revealed that this assessment was asked for and could not be provided. Continued review of records on 2/20/18 and interview with the **ON** and the **ALM** revealed that Resident #4 was admitted to the facility in [redacted], 201 7. Further review revealed that the ON Initial Assessment was completed in early , 2018, not prior to admission.	E2780		

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E2780	, Continued From page 5 Review of Resident #6's record and interview with the **DN** and ALM on 2/20/18 revealed that this resident was sent out on an emergency basis [redacted] however, upon return to the facility there was no **DN** assessment as required. Cross TAG E3330	E2780		
E 2800	.21 **A** .21 Preadmission Requirements .21 Preadmission Requirements. A. Before Move In. (1) Before admission the assisted living manager or designee shall determine whether: (a) The resident may be admitted under the assisted living program's licensure category; and (b) The resident's needs can be met by the program. (2) Within 30 days before admission, the assisted living manager or designee shall determine admission eligibilities described in §A(1) of this regulation based on completion of a resident assessment using the Resident Assessment Tool as described in §B of this regulation. The Department may modify the level of care determination made by the assisted living program at any time. The Resident Assessment Tool: (a) Determines the resident's required level of care; (b) Forms the basis for development of the resident's service plan; and (c) Determines whether the resident needs awake overnight monitoring. This REQUIREMENT is not met as evidenced by: Based on interview and record review on 2/20/18, it was determined that the facility failed to	E2800		

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E2800	Continued From page 6 complete a full assessment before admission as required. This was true for the one relevant resident record reviewed. Failure to assess residents before admission may place residents at risk. Findings include: Review of Resident #1's record on 2/20/18 revealed that this resident was admitted to the facility in· - • 2018 . Further review revealed that a Health Care Practitioner Physical Assessment was completed before admission, however the Assisted Living Manager Functional Assessment and the Level of Care Scoring Tool were not completed. These assessment forms were asked for and could not be provided.	E2800		
E3330	.26 B1,2 .26 Service Plan B. Assessment of Condition . (1) The resident's service plan shall be based on assessments of the resident's health, function, and psychosocial status using the Resident Assessment Tool. (2) A full assessment of the resident shall be completed: (a) Within 48 hours but not later than required by nursing practice and the patient's condition after: (i) A significant change of condition; and (ii) Each nonroutine hospitalization; and (b) At least annually . This REQUIREMENT is not met as evidenced by: Based on interview and record review on 2/20/18, it was determined that the facility failed to assess a resident after a hospitalization. This was true for one of the two relevant resident records	E3330		

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E3330	Continued From page 7 reviewed. Failure to fully assess residents as required may place residents at risk. Findings include: Review of Resident #6's record and interview with the DN and ALM on 2/20/18 revealed that this resident was sent out on an emergency basis - ho wever, upon return there was no assessment as required.	E3330		
E3650	.29 L .29 Medication Management and Administration .29 Medication Management and Administration. L. If a resident requires that staff administer medications as defined in Regulation .028(3) of this chapter, and the administration of medications has been delegated to an unlicensed staff person pursuant to COMAR 10.27.11, the assisted living manager shall comply with COMAR 10.27.11 by arranging for an on-site review by the delegating registered nurse at least every 45 days. The delegating nurse shall make appropriate recommendations to the appropriate authorized prescriber, and the assisted living manager or designee. This REQUIREMENT is not met as evidenced by: Based on interview and record review on 2/20/18, it was determined that the facility failed to ensure that the DN assess residents at least every 45 days. This is true for two of the five relevant resident records reviewed. Failure to ensure that the DN assess residents timely may place residents at risk.	E3650		

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E3650	Continued From **page** 8 Findings include: **Review** of **Resident** #3's record and **interview with the DN and the ALM on** 2/20/18 **revealed that the DN assessments had a gap,** and **an assessment** was due on 12/2/17. **Review** of **Resident** #6's record and interview **with the DN** and ALM on 2/20/18 revealed that the **DN assessments had** a gap **between September, 2016 and June 2017.** These documents were **asked** for **and** could not **be** provided.	E3650		

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E 000	Initial Comments On January 19, 2018 an unannounced investigation for a self-reported incident was made to the above named facility for the purpose of determining the facility's compliance with COMAR 10.07.14. Survey activities included a review of resident records and facility documentation and an interview with the Assisted Living Manager. The facility's census at the time of the survey was 49 residents . Based on survey findings, in relation to intake #MD00118960 , the facility was found to be in compliance with COMAR 10.07.14, the regulations governing assisted living programs.	E 000		

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	16AL492	A.BU L DING _____ B.v-JING _____	C 11/08/2017

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	E 000 Initial Comments On 11/08/17, an unannounced complaint investigation visit was made to the above named facility for the purpose of determining the facility's compliance with COMAR 10.07.14, Assisted Living Regulations. Survey activities included review of 1 resident record, the Medication Administration Record (MAR) , interviews with the Executive Director **(ED),** the Wellness Nurse , and the Activity Director. Based on survey findings, in relation only to complaint #MD00118518, the following deficiencies were identified on the date of the investigation.	E 000		
E36BOi	.29 **N** .29 Medication Management and Administration .29 Medication Management and Administration . **N.** Medications and treatments shall be administered consistent with current signed medical orders and using professional standards of practice. This REQUIREMENT is not met as evidenced by: Based on observation, review of resident **#1**'s record including the Medication Administration Record (MAR), interviews with the Executive Director **(ED) ,** the Wellness Nurse , and the Activity Director, the facility failed to ensure medications were administered consistent with signed orders and professional standards of practice. Failure to administer medications per the signed orders places residents at risk and	E3680		

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E3680	Continued From page 1 jeopardizes safety. Findings include: **ADMINISTRATION** Review of Resident #1's record and Medication Administration Record (MAR) on 11/08/17 revealed physician orders to administer medication #1 every evening (8pm). Review of MAR revealed that the medication was administered daily at 8am and was not administered on 07/06/17 and 07/07/17. The facility also failed to document on the reverse side of the MAR the reasons for the omission or blank spaces on the MAR. The Wellness Nurse (staff #1) stated in an interview that resident #1 requested the medication be administered in the AM and not PM. *Staff* failed to notify the physician. Further review of the resident's Medication Administration Record (MAR) revealed that medication #2 was not administered on 07/07/17 and 07/19/17 through 07/25/17 Medication #3 was also not administered on 05/16/17, 05/18/17, and 05/19/17. The facility also failed to document on the reverse side of the MAR the reasons for the omission or blank spaces on the MAR. Further interview with the Wellness Nurse *(staff* #1) also revealed that both medications were not available and thus not administered.	E3680		
E3770	I .31 A .31 Incident Reports .31 Incident Reports. A. *Staff* of the assisted living program shall complete an incident report within 24 hours of having knowledge that an incident, as defined in Regulation .028(35) of this chapter, occurred.	E3770		

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E3770	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on review of resident's record and interviews with the Executive Director (ED}, the Wellness Nurse, and the Activity Director, the facility failed to complete and ensure that an incident report was available on site for review . Findings include: On 11/08/17, observation of pictures (from Family) and an interview with the Activity Director revealed that resident #1 was taken outside by the Care Manager on a sunny day. While outside, re sident **#1** urinated and defecated and was found by family. Resident #1 was unattended, unsupervised, and there was no documented evidence of when and how long the resident was left outside in the sun. The facility failed to document or complete an incidentreport.	E3770		
E3960	.35 A1,2 .35 Resident's Rights .35 Resident's Rights. **A. A** resident of an assisted living program has the right to: (1) Be treated with consideration , respect, and full recognition of the resident's human dignity and individuality; (2) Receive treatment, care, and services that are adequate, appropriate , and in compliance with relevant State , local, and federal laws and regulations; This REQUIREMENT is not met as evidenced by Based on observation of pictures, interviews with the Executive Director (ED} , the Wellness Nurse, the Activity Director, and review of resident's record, the facility failed to ensure that resident	E3960		

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E3960	Continued From page 3 #1 received the required services and care. Findings Include: **On 11**/08/17, observation of pictures taken by family at the facility, interviews with the Executive Director **(ED),** the Wellness Nurse, and the Activity Director, revealed the facility failed to provide services and care to resident #1 by leaving the resident unattended in the sun, when resident#1 was found sitting in urine and feces.	E3960		

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E 000	Initial Comments On October 11, 2017 an unannounced self reported incident survey was conducted at the above named facili ty. Survey activities included observation of the facility, staff interviews, and review of resident files. Based on survey findings, in relation to intake number MD00118061 the facility was found to be deficient in the following regulations that govern assisted living facilities, COMAR 10.07.14. The facility's census at the time of the survey was 48 Residents .	E 000		
E2780	.20 C .20 Delegating Nurse . C. Duties . The delegating nurse shall: (1) Be on-site to observe each resident at least every 45 days; (2) Be available on call as required under this chapter or have a qualified alternate delegating nurse available on call; and (3) Have the overall responsibility for: (a) Managing the clinical oversight of resident care in the assisted living program; (b) Issuing nursing or clinical orders, based upon the needs of residents; (c) Reviewing the assisted living manager's assessment of residents; (d) Appropriate delegation of nursing tasks; and (e) Notifying the OHCQ (i) If the delegating nurse's contract or employment with the assisted living program is terminated; and (ii) Of the reason why the contract or employment was terminated.	E2780		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E2780	E2780] Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of one resident's file and an interview with the facility's Memory Care Director on October 11, 2017 it was determined that the facility's Delegating Nurse failed to assess a resident prior to the delegation of tasks to unlicensed personnel. This was true for 1 of 1 resident files reviewed. The Findings Include: Review of one resident's file on October 11, 2017 revealed that Resident #1 was admitted to the facility in - 2017 and that the Delegating Nurse had not completed either a Resident Assessment Tool or a Comprehensive Nursing Assessment on the resident until mid July 2017. An interview with the memory care director on October 11, 2017 revealed that the delegating nurse working at the facility at the time of the incident was no longer an employee and the facility was unable to provide a Resident Assessment Tool or Comprehensive Assessment for Resident #1 before mid July 2017.			

Office of Health Care Quality

STATEMENT OF DEFICIENCIE S AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE R/CU A IDENTIFI CATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A.BU I L D I NG _____ B V111NG _____	C 09/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRE SS, CITY. STATE, ZIP CODE
HEARTFIELDS AT BOWIE	**7600 LAUREL BOWIE ROAD BOWIE, MD 20715**

(X4) ID PREFIX TAG	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
M MARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			

Office of Health Care Quality

E 000 Initial Comments		E 000	

On September 1, 2017 an unannounced complaint investigation was made to the above named facility for the purpose of determining the facility's compliance with COMAR 10.07.14. Survey activities included a review of resident records, facility documentation and an interview with the Alzheimer's Director.

The facility's census at the time of the survey was 48 residents.

Based on survey findings, in relation only to Complaint# MD00116533, the facility was found to be in compliance with COMAR 10.07.14, the regulations governing assisted living programs.

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LABORATORY DI RECTOR'S OR PR OVIDER/SUPPLIERREPRESENTATIVE'SSIGNATURE | TITLE | (X6) DATE

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING:_____ B. WING_____	C 08/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORYOR LSC IDENTIFYINGINFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
E OOO	Initial Comments On 08/09/2017, an unannounced visit was made to the above named facility to conduct a complaint investigation. Survey activities included obse rvation, interviews with the Resident Services Director/Delegating Nurse /Case Manager (ON/CM) and review of administrative and resident records. Based on survey findings, in relation only to the complaint# MD00115971 the following deficient practice(s) were identified as a result of the investigation.	E 000		
E3360	.26 C1 .26 Service Plan C. The assisted living manager, or designee, shall ensure that: (1) A written service plan or other documentation sufficiently recorded in the resident's record is developed by staff, which at a minimum addresses: (a) The services to be provided to the resident, which are based on the assessment of the resident; (b) When and how often the services are to be pr ovided; and (c) How and by whom the services are to be pr ovided; This REQUIREMENT is not met as evidenced **by:** Based on resident record reviews and interview with the Delegating Nurse/Case Manager (DN/CM), the facility failed to ensure that service plans were tailored to the specific needs of the individual resident. Failure to individualize service plans places residents at risk of not having needed services met.	E3360		

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

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING _____ B. WING _____	C 08/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E3360	Continued From page 1 Findings include: Review of resident records and an interview with the **DN/CM,** revealed no documented evidence of individualization of Resident #1's service plan specific to diagnoses, capabilities, and level of dependence/independence.	E3360		

Office of Health Care Quality

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUL DING : _____ B. WING_____	C 04/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE. ZIPCODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEDBY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACHCORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
E ooo	Initial Comments On April 18, 2017, an unannounced complaint investigation visit was made to the above named facility for the purpose of determining the facility's compliance with COMAR 10.07.14, Assisted Living Regulations. Survey activities included resident record reviews, incident reports reviews, review of facility records including menu plans, activity rosters, and emergency call logs, interview of staff, and observation of the environment. Based on survey findings, in relation only to complaint# MD00112519, the following deficiencies were identified on the date of the investigation. The facility's census at the time of the survey was 46 residents.	E 000		
E2820	.21 81 ,2,3 .21 Preadmission Requirements 8. Resident Assessment Tool. (1) Within 30 days before admission, the assisted living program shall collect, on the Resident Assessment Tool written information about a potential resident's physical condition and medical status. (2) Information on the Resident Assessment Tool shall be based on an examination conducted by a primary physician, certified nurse practitioner, certified registered nurse midwife, registered nurse, or physician assistant who shall certify that the information on the Assessment reflects the resident's current health status. (3) If the potential resident is admitted on an emergency basis by a local department of social services, the required assessment using the Resident Assessment Tool shall be completed as soon as possible but no later than 14 days of the emergency admission.	E2820		

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

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STATEMENTOF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING: _____ B. WING _____	C 04/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

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E2820	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview with 1 of 2 staff, it was determined that the Delegating Nurse (ON) failed to ensure that the Resident Assessment Tool (RAT) reflects the assessment findings of the resident's current health Status. This was true for 1 resident's record reviewed. Failure to ensure that the RAT reflects the resident's current health status places the resident at risk for harm. Findings include: Review of Resident #1's record on April 18, 2017 revealed a RAT completed by the ON on February 18, 2017 which did not included two diagnosis and treatment that Resident #1's physician had diagnosed and ordered. Continuous review revealed that Resident #1 was being treated for the two conditions as December 2016 as documented on Resident #1's signed physician's order form. This was confirmed in an interview with the Delegating Nurse on April 19, 2017.	E2820		
E3330	1,2 .26 Service Plan B. Assessment of Condition. (1) The resident's service plan shall be based on assessments of the resident's health, function, and psychosocial status using the Resident Assessment Tool. (2) A full assessment of the resident shall be completed: (a) Within 48 hours but not later than required by nursing practice and the patient's condition after: (i) A significant change of condition; and	E3330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPP LIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLECONSTRU CTION	X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING:_____ B. Vv1NG_____	C 04/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRE SS, CIT Y, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	**7600 LAUREL BOWIE ROAD BOWIE, MD 20715**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E3330	Continued From page 2 (ii) Each nonroutine hospitalization; and (b) At least annually. This REQUIREMENT is not met as evidenced by: Based on record review and interview with 2 of 2 staff, it was determined that the facility failed to ensure that the Delegating Nurse (ON) completed a full assessment of the resident after a significant changes in health status. This was true for 1 resident's record reviewed. Failure to complete a full assessment of the resident after a changes in health status places the resident at risk for harm. Findings include: Review of Resident #1's record on April 18, 2017 revealed that the ON completed a full assessment of Resident #1 on February 18, 2017. No other documentation or assessment was noted in Resident #1's record of a full assessment, despite the results of an x-ray which indicated an acute change in Resident #1's heart health. Further review revealed an order from Resident #1's physician after receiving the test results to change Resident #1's medication treatment. This was confirmed in an interview with the Assisted Living Manager on April 18, 2017, and the **ON** on April 19, 2017.	E3330		
E3380	.26 C3 .26 Service Plan (3) The service plan is reviewed by staff at least every 6 months, and updated, if needed, unless a resident's condition or preferences significantly change , in which case the assisted living	E3380		

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STATEMENT OF DEFICIEN CIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER /CU A IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	X3) DATE SURVE Y COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X 4) ID PREFIX TAG	SUMMARY STATE MENT OF DEFI CIENCIE S (EACH DEFICIENCY MUST BE PRECEDEDBY FULL REGULATORY OR LSC IDENTIF YING INF ORMATION)	ID PREFIX TAG	PROVIDER'S PLA N OF CORRECTI ON (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFEREN CED TO THE APPROPRI ATE DEFICIENC Y)	(XS) CO MPLETE DATE
E3380	Continued From page 3 manager or designee shall review and update the service plan sooner to respond to these changes. This REQUIREMENT is not met as evidenced by: Based on record review and interview with 1 of 2 staff, the facility failed to review and update the service plan when a significant change in the resident's status occurred. This was true for 1 resident's record reviewed. Failure to review and update the service plan may result in harm. Findings include: Review of Resident #1's record on April 18, 2017, revealed a service plan dated February 18, 2017, which was not reviewed or updated; despite an acute change to Resident #1's chronic condition confirmed by blood test on February 2, 2017 and an acute change confirmed by x-ray on April 4, 2017. This was confirmed in an interview with the Assisted Living Manager on April 18, 2017.	E3380		

Office of Health Care Quality

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	16AL492	A. BUILDING:_____ B. WNG_____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS , CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

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	E oool Initial Comments On September 22, 2016, an unannounced complaint investigation visit was made to the above named facility for the purpose of determining the facility's compliance with COMAR 10.07.14, Assisted Living Regulations. Survey activities included resident record reviews, incident reports reviews, review of facility records, interview of staff and residents, tour of the facility and observation of the environment. Based on survey findings, in relation only to complaint #'s MD00105083, MD00105087 and MD00102364, the following deficiencies were identified on the date of the investigation. The facility's census at the time of the survey was 44 residents.	E 000		
	E2780 .20 C .20 Delegating Nurse C. Duties. The delegating nurse shall: (1) Be on-site to observe each resident at least every 45 days; (2) Be available on call as required under this chapter or have a qualified alternate delegating nurse available on call; and (3) Have the overall responsibility for: (a) Managing the clinical oversight of resident care in the assisted living program; (b) Issuing nursing or clinical orders, based upon the needs of residents; (c) Reviewing the assisted living manager's assessment of residents; (d) Appropriate delegation of nursing tasks; and (e) Notifying the OHCQ (i) If the delegating nurse's contract or employment with the assisted living program is terminated; and (ii) Of the reason why the contract or employment was terminated.	E2780		

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LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE | TITLE | (X6) DATE

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIO N NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING: _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

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	E2780 Continued From page 1	E2780		

This REQUIREMENT is not met as evidenced by
Based on review of the Resident's record, facility's records , a death certificate and interview with 2 of 5 Staff, the facility failed to ensure that the delegating nursing (DN) managed the clinical oversight of the resident's care during a change in health status. Failure to manage the clinical oversight may result in harm or injury to the resident.

Findings include:

Review of Resident #1's record on September 22, 2016, revealed that on May 2, 2016, Resident #1 presented with an acute onset of cough and congestion. Continu ous review revealed that Resident #1's physician and the DN were made aware. Continuous review revealed that no nursing assessment by the DN was completed within 48 hours or 7 days after being made aware of the change in Resident #1's health status. Continuous review revealed that no documentation that the DN ensured that the new orders by Resident #1's physician, in relation to the acute onset of cough and congestion, were followed. Further review of Resident #1's record revealed that five (5) medication errors were identified according to the medication administration record (MAR), which records the new orders prescribed by Resident #1's physician to treat the acute onset of cough and congestion. Further review of facility's monthly documentation of at risk residents revealed that Resident #1 was recorded for falls in the month of May, 2016, but did not include any documentation of the acute onset, diagnosis, treatment or services.

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E2780	E2780 Continued From page 2 , Interview with the ON and Assisted Living ' Manager (ALM) on September 22, 2016, revealed that the ON does not follow the regulation of 45 days assessments , being that he/she is a staff onsite nurse and the staff that administer medications are licensed practical nurses (LPN). The ON further stated that he/she was unaware of the medication errors. The ON further stated that the he/she was aware of the acute onset of the cough and congestion, new orders for x-rays and medication, but did not evaluation the LPN's implementation of the new orders. ; Review of Resident #1's death certificate on October 14, 2016, revealed that Bronchitis was listed as condition leading to immediate cause of : death (due to or as consequence of). Resident · #1 was pronounced dead , - after the acute onset of cough and congestion. Reference tags: Nurse Practice Act 10.27.09 03 (I) 2 (c) Delegating to licensed nurse, ! The RN assigning a nursing act to another licensed nurse, shall: Verify that the nursing act is within the licensed nurse's legal scope of practice; nurse : has knowledge, skills and clinical competency to perform the assigned act; act is consistent with the facility's policies and procedures; RN regularly evaluate the licensed nurse who is performing the assigned nursing act; rectify a situation in which the licensed nurse assigned to perform the nursing act has performed the nursing act incorrectly and prohibit the continued performance of the assigned nursing act by a licensed nurse who is performing the assigned nursing act or acts incompetently.	E2780		

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	E2780 Continued From page 3	E2780		

COMAR 10.07.14.26 B 2 a full assessment of the resident shall be completed within 48 hours after a significant change of conditions, ensure that full assessment of the resident is conducted within 7 calendar days.

. Repeat deficiency tag see survey dated January 15, 2016

E3380i .26 C3 .26 Service Plan — E3380

(3) The service plan is reviewed by staff at least : every 6 months, and updated, if needed, unless a resident 's condition or preferences significantly change, in which case the assisted living manager or designee shall review and update the service plan sooner to respond to these changes.

This REQUIREMENT is not met as evidenced by:
Based on review of the resident's record, and interview with 1 of 5 staff, the facility failed to review and update the service plan every 6 months . This was true for 1 of 1 resident's record reviewed. Failure to review and update the service plan may result in medical and nursing needs not being met.

Findings include:

! Review of Resident #1's record on September 22, 2016, revealed a service plan dated November 30, 2015, which was not reviewed or updated, despite a significant change of Resident #1's condition. Further review of Resident #1's record revealed a acute onset of cough and congestion resulting in two physician visits for evaluation, two x-rays to diagnose presenting condition, and three adjustments to medication therapy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E3380	Continued From page 4 Interview with the Delegating Nurse (ON) on September 22, 2016, revealed that the service plan date November 30, 2015, was the last service plan created and updated for Resident #1.	E3380		
E36ao	**M** .29 Medication Management and Administration M. Medications and treatments shall be administered consistent with current signed medical orders and using professional standards of practice. This REQUIREMENT is not met as evidenced by: Based on review of the resident's record and interview with 2 of 5 staff, the facility failed to ensure that all medications were issued according to signed medication orders. This was true for 1 of 1 resident's record reviewed. Failure to administer medication in accordance with signed medical orders may result in harm to resident. Findings include: Review of Resident #1's record on September 22, 2016, revealed a medication administration record (MAR) charting for May 1, to May 31, 2016. Continuous review revealed signed orders dated 5/4/2016, 5/5/2016 and 5/19/2016. Continuous review revealed Robitussin prescribed on 5/4/2016, to be given by mouth 5 ml every 6 hours for cough, was transcribed onto the MAR as an as needed (PRN) medication order. Resident #1 was not given 71 doses of	E3680		

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HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

P!X	SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID TAG PREFIX	PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVEACTION SHOULD BE DEFICIENCY)	(X5) DATE COMPLETE
E3680	, Continued From page 5 this medication, despite a signed physician's order to treat the acute onset of cough and congestion. Tesslon pearls was prescribed for Resident #1 with a caution to report to the physician if Resident #1's temperature is greater than 100.5. Further review of Resident #1's record did not reveal any documentation that Resident #1's temperature was being monitor or recorded during the course of this treatment as ordered. Continuous review of Resident #1's MAR revealed omissions of Lasix and KCL without documentation of reason for not giving the medication; despite an order dated 5/5/16 to give. Interview with the Delegating Nurse (ON) on September 22, 2016, revealed that the ON was unaware of the medication errors. Repeat deficiency tag see survey dated January 15, 2016	E3680		
E3960	.3 5 A1,2 .35 Resident's Rights . 35 Resident's Rights . A. A resident of an assisted living program has the right to: (1) Be treated with consideration, respect, and full recognition of the resident's human dignity and individuality; (2) Receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant State, local, and federal laws and regulation s; This REQUIREMENT is not met as evidenced by	E3960		

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E3960	Continued From page 6 Based on resident's record review and interview with 2 of 5 staff, the facility failed to ensure that the resident received care and services from unlicensed staff that meets the needs of the re sident; base on the health status and standards of practice. This was true for 1 of 2 resident's record reviewed. Failure to provide the care and service that meets a resident's needs may result in injury or harm to the resident. Findings include: Review of Resident #2's record on September 22, 2016, revealed an incident report, and nurse's investigation note that records that Resident #2 suffered injury due to Staff #1's actions while caring for Resident #2. Further review revealed a hospital discharge summary of Resident #2 being treated for a closed head injury. Further review of Resident #2's record revealed a service plan that recorded Resident #2 requires 2 or 3 person assist with care. Continuous review revealed Staff #1 entered Resident #2's room and noticed Resident #2 lying close to the wall and pull the bed away from the wall. Resident #2 fell out of the bed onto the floor as a result of Staff #1 pulling the bed away from the wall; causing injury to Resident #2. Interview with the Delegating Nurse on September 22, 2016, revealed that Staff #1 confessed to pulling the bed containing Resident #2 away from the wall causing injury to Resident #2. Staff #1 was terminated as a result of violating facility's policy and procedure.	E3960		

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STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A.BUILDING: _____ B.'MNG_____	C 06/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	**7600 LAUREL BOWIE ROAD BOWIE, MD 20715**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
E OOO	Initial Comments On 6/17/2016, a review of the Department records revealed that the allegations, in relation only to intake # 00101443, were previously investigated by the Department on 5/20/2015 on a complaint survey.	E 000		

OHCQ

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

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING: _____ B. WING _____	C 05/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
E 000	Initial Comments On 5/20/2015, an unannounced visit was made to the above named facility to conduct a complaint investigation and to follow up on two self-reported incidents. Survey activities included a review of two residents' records and the facility documentation. On 5/24/2016, a second announced visit was made to the facility to review a closed resident's record and to interview the facility staff members. Based on survey findings, in relation only to intake# **MD** 00100884, # MD 00101351 and# MD 00100623, the following deficiencies were identified on the dates of the investigation. The facility's census at the time of the survey was forty-eight (48) residents.	E 000		
E3330	.26 B1,2 .26 Service Plan B. Assessment of Condition. (1) The resident's service plan shall be based on assessments of the resident's health, function, and psychosocial status using the Resident Assessment Tool. (2) A full assessment of the resident shall be completed: (a} Within 48 hours but not later than required by nursing practice and the patient's condition after: (i) A significant change of condition; and (ii) Each nonroutine hospitalization; and (b} At least annually. This REQUIREMENT is not met as evidenced **by:** Based on an interview of the facility staff members and a review of a resident's record, the facility failed to ensure that a full assessment of the resident was completed after acknowledging	E3330		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E3330	Continued From page 1 that the resident had a significant change of condition. Findings include: Resident #1 is a with diagnosis of Dementia. On 4/10/2016, was discovered with a wrist and knee abrasions and skin discoloration. The resident stated that fell but was unable to provide the details. On 4 /10/16, the resident was taken to a health center for examination and evaluation. On_ , the was taken to a hospital for evaluation of possible Cervical spine fracture and potential surgery. On 5/20/16, a review of Resident #1's record failed to reveal documentation indicating that a full assessment of the resident was conducted after the resident's 4/10/16 fall.	E3330		

Office of Health Care Quality

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E 000	Initial Comments On April 1, 2016, an on-site unannounced complaint investigation survey was conducted. Complaint investigation, **MD** 00099230 was initiated in response to the allegations. Investigation activities included tour of the facility and observation, interview with the Alzheimer's unit Director and review of one resident closed records. The licensee was found to be compliant with COMAR title 10.07.14 regulations.	E 000		

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	16AL492	A. BUILDING: _____ B. WING_____	C 01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE, ZIP CODE
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E 000	Initial Comments On January 15, 2016, an unannounced complaint investigation visit was made to the above named facility for the purpose of determining the facility's compliance with COMAR 10.07.14 , Assisted Living Regulations. The allegation was elopement of a resident. Survey activities included resident's record review, incident reports reviews, review of facility records including verbal physician order forms, interview of *staff,* and observation of the environment. Based on survey findings , in relation only to complaint# MD00097325, the following deficiencies were identified on the date of the investigation. The facility's census at the time of the survey was forty-one {41} residents.	E 000		
E2780	.20 C .20 Delegating Nurse C. Duties. The delegating nurse shall: (1) Be on-site to observe each resident at least every 45 days; (2) Be available on call as required under this chapter or have a qualified alternate delegating nurse available on call; and (3) Have the overall responsibility for: (a) Managing the clinical oversight of resident care in the assisted living program; (b) Issuing nursing or clinical orders, based upon the needs of residents; (c) Reviewing the assisted living manager's assessment of residents; (d) Appropriate delegation of nursing tasks; and (e) Notifying the OHCQ: (i) If the delegating nurse's contract or employment with the assisted living program is	E2780		

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E2780	E2780 Continued From page 1 terminated; and (ii) Of the reason why the contract or employment was terminated. This REQUIREMENT is not met as evidenced by: Based on review of Resident's record and interview with staff, it was determined that the Delegating Nurse (DN) failed to: 1. appropriately delegate the administration of medication and treatment. 2. issue orders to hold the administration of medication until a signed order is obtained from a physician or person authorized by law to prescribe medication and/or treatment. This was true for 1 of 1 resident's record revie wed. Delegating the task of medication administration and treatment without a signed physician's order may result in harm and injury to the resident. Findings include: Review of Resident #1 record on January 15, 2016 , revealed six (6) verbal physician's orders form written by the register nurse **(RN)** and licensed practical nurse (LPN) of this facility's staff, that were faxed to a physician to obtain a signature to validate new orders, changes to current orders, and/or discontinue an order based on the needs of the resident. The form processed documentation that the form was faxed to the physician, but no physician signature was obtained to administrator the requests. A form dated 12/11/2015 to decrease night time lantus 1OOu/ml subq everyday to 20 units for type 2 diabetes mellitus to repeated and confirmed was faxed to the physician on 12/11/1015. No returned fax with the physician's signature was	E2780		

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E2780	Continued From page 2 documented in Resident #1's record. Further review revealed a medication administration record **(MAR)** for charting period of December 2015, documenting that Lanius 100u/ml was given seven (7) times at 20 units without a signed physician's order. Continuous review of Resident #1's record revealed a verbal physician's order form that was faxed to the physician dated 12/12/2015 to validate orders, discontinue Risperidone 0.25mg twice daily (bid), start Risperidone 0.25mg by mouth (po) daily (q) in the morning (am) for agitation/psychosis , Risperidone 0.5mg po q hour of sleep (hs) for agitation/psychosis, and "transfer resident (rsdt) from AL to BTR due to elopement". No returned fax with the physician's signature was documented in Resident #1's record. Further review of the MAR for charting period of December 2015, revealed that the previous stated order were performed for 28 days without a signed physician's order. Continuous review of Resident #1's record revealed a verbal physician's order form that was faxed to the physician dated 12/15/15 to validate orders, start levaquin 500 mg give one tablet po q day possible urinary tract infection (UTI) for 7 days STAT, Tylenol 325 mg 2 tabs po q 6 hours as needed (PRN) for fever, labs CBC/CMP in the m orning. These orders were performed without obtaining the signature of a physician or the signature of a person authorized by law to prescribe medication and treatment for 31 days. Continuous review of Resident #1's record revealed a verbal physician's order form that was faxed to the physician dated 1/1/2016 to use Novolog flex pen 100 units/ml use as directed STAT. Further review of Resident #1's record	E2780		

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E2780	Continued From page 3 revealed that no returned fax with a physician's signature was obtained for 14 days as of the date of this survey. Continuous review of Resident #1's record revealed a verbal physician's order form that was faxed on 1/9/2016 to the physician to clarify an order to discontinue Exelon patch 4.5mg and start Exelon patch 4.6mg apply topically daily for dementia. Further review of Resident #1's record revealed no signature was obtained for 6 days, as of the date of this survey, and the Exelon patch 4.5mg was discontinued on 1/9/2016, as documented on the MAR charting for January 2016 without a signed order. Review of these documents on January 15, 2016 revealed that the ON delegated the task to administrator medication and treatment without the authorization of a physician or person authorized by law to prescribe medication or treatment. Further review of Resident #1's record revealed at Resident Assessment Tool (RAT) which documented that a three way check (which insist of ensuring that a signed order, MAR, and the medication container has the same name of the resident, name of medication, dose, route, frequency) prior to administrating the medication has been done. The standard of practice and the requirement as provided in the Maryland Medication Technician Training Program (MMTTP) is that each time a medication is administered; staff must conduct a "three way check". The ON signed the RAT stating that this three way check had been complete for all of Resident #1's medications and treatment despite not having signed physician orders for medications delegated and given to Resident #1. Interview with the Assisted Living Manager (ALM) and ON on January 15, 2016 revealed that the	E2780		

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E2780	Continued From page 4 DN requested time to search for the signed order because they may be placed some where else and not placed in the file. The **DN** later returned and confirmed that no signed orders were in the facility. Continued Non-compliance survey conducted November 20, 2015	E2780		
E3420	.27 D .27 Resident Record or Log D. Resident Care Notes. (1) Appropriate staff shall write care notes for each resident: (a) On admission and at least weekly; (b) With any significant changes in the resident's condition, including when incidents occur and any follow-up action is taken; (c) When the resident is transferred from the facility to another skilled facility; (d) On return from medical appointments and when seen in home by any health care provider; (e) On return from nonroutine leaves of absence; and (f) When the resident is discharged permanently from the facility, including the location and manner of discharge. (2) Staff shall write care notes that are individualized, legible, chronological, and signed by the writer. This REQUIREMENT is not met as evidenced by: Based on review of resident's record, the facility failed to ensure that weekly care notes were documented . This was true for 1 of 1 resident's record reviewed. Findings include:	E3420		

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NAME OF PROVIDE R OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	**7600 LAUREL BOWIE ROAD BOWIE, MD 20715**

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E3420	Continued From page 5 Review of Resident #1's record on January 15, 2016 , revealed the last weekly care note was documented on 12/20/2015. On the date of this survey, Resident #1 had returned to the facility on the evening of , from an emergency visit via ambulance. Resident #1 was sent to the hospital on , from this facility. Continued Non-compliance survey conducted November 20, 2015	E3420		
E3470	. 28 C .28 Services C. Nursing Services. The assisted living manager, in consultation with the delegating nur se, shall ensure that all nursing services are provided consistent with the Nurse Practice Act , Health Occupations Article, Title 10, Annotated Code of Maryland. This REQUIREMENT is not met as evidenced by: Based on review of resident's record and interview with staff, the facility failed to consult with the delegating Nurse (ON) to ensure that all medication order were signed by a physician, or individual who is authorized by law to prescribe medication or treatment, prior to delegating the task of administrating new or change medication orders and treatment to the resident. The Maryland Board of Nursing scope of practice declare that licensed or unlicensed staff may not administer treatment or medication unless the medication or treatment is prescribed by an individual who is authorized by law to prescribe medication or treatment. This was true for 1 of 1 resident record reviewed . Failure to have a	E3470		

STATEMENT OF DEF ICIENCIES AND PLAN OF CORRECTI ON	(X1) PR OVIDER /SUPPLIE R/C UA IDENTIFICA TION NUMBER:	(X2) MULTIPLE CONSTRU CTION	(X3) DATE SURVEY COMPLET ED
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E3470	Continued From page 6 system in place to ensure medication and/or treatment is administrated when prescribed may result in harm or injury to the resident. Findings include: Review of Resident #1's record on January 15, 2016 revealed seven (7) verbal physician's orders forms that requested the validation to change current orders, start new order, discontinue current orders, or institute new treatment for Resident #1. Further view revealed that none of the 7 orders that were faxed to the physician was returned to the facility with the physician's signature to validate the physician's orders for Resident #1. Interview with the Assisted Living Manager and ON on January 15, 2016 revealed that the ALM and **ON** were not aware that a physician's signature was not obtained for any of the 7 orders. The ON and ALM asked if they could look in other places in the facility to see if the order were signed and returned to the facility, but not filed in Resident #1's record. The ON and ALM later stated that no signed orders were in the facility.	E3470		
E3 6B0	.29 M .29 Medication Management and Administration M. Medications and treatments shall be administered consistent with current signed medical orders and using professional standards of practice. This REQUIREMENT is not met as evidenced by:	E3680		

Office of Health Care Quality

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E3680	Continued From page 7	E3680		

Based on review of resident record and interview of staff, the facility failed to ensure that all medications were issued according to signed medication orders. This was true for 1 of 1 resident record reviewed and interview of 2 of 2 staff. Failure to administrate medication in accordance with medical orders may result in harm to resident.

Findings include:

Review of Resident #1's record on January 15, 2016, revealed a medication administration record (MAR) for the charting period of December 2015, and January 2016. Further review of the MAR revealed multiple omission of medication without a documented reason for each omission, despite a signed order to give the prescribed medication at an ordered dose, route, and frequency with a date to start.

Continuous review revealed an order for treatment to obtain blood glucose monitoring via finger stick three (3) times daily. This order was signed by a physician on 12/2/15 for Resident #1. Further review of the MAR for Resident #1, dated for charting period December 2015, revealed that finger sticks were taken and recorded four (4) times daily; despite the signed order to conduct finger sticks 3 times daily.

Continuous review of Resident #1 record revealed a signed physician's order dated 12/2/15, prescribing Novolog penfill 100 units/ml subcutaneous solution to be given according to a sliding scale, which was listed on the order, via subcutaneous injection once daily (QD) for Diabetes Mellitus (DM2). Further review of Resident #1's record revealed a **MAR** charting period December 2015, which documented that

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E3680	Continued From page 8 Novolog was giving to Resident #1 four times daily according to the ordered sliding scale, despite the signed physician's order to give one (**1**) time daily. Review of the MAR for Resident #1, charting period January 2016, Novolog was giving to Resident #1 three (3) times daily, despite a signed order to give one (1) time daily.	E3680		

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E 0001	Initial Comments On November 20, 2015, an unannounced complaint investigation visit was made to the above named facility for the purpose of determining the facility's compliance with COMAR 10.07.14, Assisted Living Regulations. The allegation was an unexpected death of a resident. Survey activities included resident's record review, incident report review, review of facility records including police report; interview with staff and observation of the environment. Based on survey findings, in relation only to complaint #MD00096029 , the following deficiencies were identified on the date of the investigation. Complaint #MD00096034 was conducted by another nurse surveyor prior to this investigation visit. The facility presented a Statement of Deficiency issued by another nurse surveyor. The facility's census at the time of the survey was forty-six {46} residents.	E 000		
E2780	20 C .20 Delegating Nurse C. Duties. The delegating nurse shall: (1) Be on-site to observe each resident at least every 45 days; (2) Be available on call as required under this chapter or have a qualified alternate delegating nurse available on call; and (3) Have the overall responsibility for: (a) Managing the clinical oversight of resident care in the assisted living program;	E2780		

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E2780	E2780 Continued From page 1 (b) Issuing nursing or clinical orders, based upon the needs of residents; (c) Reviewing the assisted living manager's assessment ofresidents; (d) Appropriate delegation of nursing tasks; and (e) Notifying the OHCQ: (i) If the delegating nurse's contract or employment with the assisted living program is terminated; and (ii) Of the reason why the contract or employment was terminated. This REQUIREMENT is not met as evidenced by: Based on review of 1 of 1 resident's record and interview with staff, the facility failed to ensure that the delegating nursing (DN) had blood work that was ordered by a physician drawn. The failure to manage the clinical oversight was true for 1 of 1 resident's record reviewed. Failure to complete an order request by a physician may result in harm or injury to resident. Findings include: Review of Resident #1's record on November 20, 2015 revealed a physician's order dated 10/1/15 to have blood lab drawn. Interview with the **DN** on November 20, 2015] revealed that the blood draw was not completed.			
E3420	E3420l .27 D .27 Resident Record or Log D. Resident Care Notes. (1) Appropriate staff shall write care notes for each resident:			

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HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

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E3420	, Continued From page 2 (a) On admission and at least weekly; (b) With any significant changes in the resident's condition, including when incidents occur and any follow-up action is taken; (c) When the resident is transferred from the facility to another skilled facility; (d) On return from medical appointments and when seen in home by any health care provider; (e) On return from nonroutine leaves of absence; and (f) When the resident is discharged permanently from the facility, including the location and manner of discharge. (2) Staff shall write care notes that are individualized , legible, chronological, and signed by the writer. This REQUIREMENT is not met as evidenced by: Based on review of resident's record, the facility failed to ensure that weekly care notes were d ocumented. This was true for 1 of 1 resident's record reviewed. Findings include: , Review of Resident #1's record on November 20, 2015 revealed the last weekly care note was documented on 9/12/15.	E3420		

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	16AL492	A.BUILDING:_____ _VVING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS , CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEDBY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS -REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
E 0001 Initial Comments	On November 6, 2015, an unannounced complaint investigation visit was made to the above named facility for the purpose of deter mining the facility's compliance with COMAR 10.07.14. The allegation was injury to a resident of unknown origin. Survey activities included resident record review, review of facility incident report and interview with staff. Based on survey findings, in relation only to complaint# MD00095882, the facility was found to be in compliance with the regulations governing assisted living facilities, COMAR 10.07.14. The facility's census at the time of the survey was forty-eight (48) residents.	E 000		

OHCQ

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

Office of Health Care Qualitv

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING:_____ B. \NING_____	C 10/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4)ID P REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
E 000	Initial Comments On October 6, 2015, an on-site complaint investigation was conducted in response to self report allegations that a staff verbally abused a resident. Complaint investigation, MD 00094954 was initiated in response to the allegations. Investigation activities included interview withthe Executive Director and Delegating Registered Nurse and review of one resident record and one staff personnel file. The facility was found to be out of compliance with COMAR title 10.07.14 regulations .	E 000		
E4180	.36 C1 .36 Abuse, Neglect, & Financial Exploitation C. Reports of Abuse, Neglect, or Financial Exploitation. (1) A licensee or employee of an assisted living program who has witnessed, or otherwise has reason to believe, that a resident has been subjected to abuse, neglect, or financial exploitation shall report the alleged abuse, neglect, or exploitation within 24 hours to: (a) The appropriate local department of social se rvices, Adult Protective Services Program; and (b) One or more of the following: (i) A local law enforcement agency; (ii) The Office of Health Care Quality of the Department; (iii) A representative of the Long-Term Care Ombudsman Program in the Department of Aging or local area agency on aging. This REQUIREMENT is not met as evidenced by: Based on review of records and interview with facility staff the facility failed to report verbal abuse of one resident to Adult protective Services.	E4180		

OHCQ

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

Office of Health Care Qualitv

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING:_____ B. VvlNG_____	C 10/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
E41B0	Continued From page 1 Resident# 1 was admitted to the facility with diagnoses which included Alzheimer Disease. This resident is confused and is dependent on facility staff with assistance with [redacted]vities of daily living and supeNision. Review of the the resident Incident Report on October 6, 2015 revealed on September 13, 2015 the resident refused to get out of bed and refused to take a bath. Further review revealed the care manager insisted the resident get out of bed and have a bath when [redacted]ntinued to refuse the care manager took a trash can of water and threatened to throw it on the resident Telephone inteNiew with the Executive Director on October 6, 2015 revealed the staff member was terminated and the Maryland Board of Nursing was notified. Further inteNiew revealed the Adult Protective SeNices was not notified of the incident as required by the regulations.	E4180		

Office of Health Care Quality

STATEMENT OF DEFICIENC IES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	16AL492	A. BU I L D I NG _____ B. 'MNG _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED *TO* THE APPROPRIATE DEFICIENC Y)	(XS) COM PLETE DATE
E 0001 Initial Comments		E 000		

On July 24, 2015, an unannounced complaint investigation visit was made to the above named facility for the purpose of determining the facility's compliance with COMAR 10.07.14. The allegation was redness of the right eye of a resident which was of unknown course. This was self-reported by the facility's administration.

Survey activities included review of resident record, review of facility records, and interview of facility staff.

Based on survey findings, in relation only to complaint# MD00092154, the facility was found to be in compliance with the regulations governing assisted living facilities, COMAR 10.07.14.

OHCQ

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

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFIC ATION NUMBER:	(X2) MU TIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	16AL492	A BU I LD I NG _____ B. WING _____	07/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRE SS, CIT Y, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYIN G INF ORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X S) COMPLETE DATE
E 000	Initial Comments On July 20 and 21, 2015, an announced visit was made to the above named facility for the purpose of conducting an inspection of care survey. Survey activities included an environmental tour; review of six (6) randomly selected resident records ; review of policies and procedures for the facil ity; review of the training records for the assisted living manager (ALM), the alternate assisted living manager (AALM)/delegating registered nurse/case manager (ORN/CM), and three (3) staff; and interview of three (3) re sidents, two (2) staff, the ALM and the AALM/DRN/CM. The census at the time of the survey was forty-two (42) residents. Based on survey findings, the facility was found to be in violation of the regulations governing assisted living facilities , COMAR 10.07.14.	E 000		
E2sso	. 19 B2 .19 Other Staff--Quali fications (2) As evidenced by a physician's statement be free from: (a) Tuberculosis, measles, mumps, rubella, and varicella through appropriate screening procedures such as tuberculosis skin tests, positive disease histories, or antibody serologies; and (b) Any impairment which would hinder the performance of assigned responsibilities ; This REQUIREMENT is not met as evidenced by Based on record review and interview, the facility failed to ensure that employees' files contained medical documentation required by the Department.	E2550		

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LABORATOR Y DIRECTOR'S OR PROVIDER/SUPPLIERREPRESENTATVE'S SIGNATURE | TITLE | (X6) DATE 08/09/15

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A BUILDING:_____ B. WING_____	07/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E2550	Continued From page 1 Findings included: At the time of the survey, the documentation provided to indicate immunity to rubella and mumps revealed the following: 1) Staff #2's health record noted that she did not know whether she had had the disease or the immunizations for mumps or rubella; and 2)Staff #3's health record had no indication as to whether she had had mumps or had been vaccinated against mumps. The ALM related that the facility's Infectious Communicable Disease Form was reviewed by the facility's business office manager when staff had completed and returned this questionnaire. The ALM further noted that he was unaware that some returned questionnaires did not provide required documentation of immunity to mumps and rubella. Therefore, the facility failed to ensure immunity to mumps and rubella was documented for two (2) out of five (5) employee records reviewed.	E2550		
E3720	.30 A .30 Alzheimer's Special Care Unit .30 Alzheimer 's Special Care Unit. A. Written Description. At the time of initial licensure, an assisted living program with an Alzheimer's special care unit shall submit to the Department a written description of the special care unit using a disclosure form adopted by the Department. The description shall explain how: (1) The form of care and treatment provided by the Alzheimer's unit is specifically designed for the specialized care of individuals diagnosed with Alzheimer's disease or a related dementia; and (2) The care in the special care unit differs from	E3720		

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	16AL492	A. BUILDNG : _____ B. VvlNG _____	07/21/2015

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HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

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E3720	Continued From page 2	E3720		

the care and treatment provided in the nonspecial care unit.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the facility failed to ensure that there was a specific Uniform Disclosure Statement for the facility's Alzheimer's/dementia care unit (Bridges to Rediscovery) which included components mandated by the Department for an Alzheimer's Special Care Unit.

Findings included:

At the time of the survey, the ALM related that the facility had one (1) Uniform Disclosure Statement which was utilized for both the traditional assisted living portion of the facility as well as for the Alzheimer's/dementia care portion of the facility which the ALM noted was called Bridges to Rediscovery, or more frequently, BTR. He further noted that additional training for those staff assigned to the BTR unit was documented in the one (1) facility Uniform Disclosure Statement. However, the facility's single Uniform Disclosure Statement did not include admission procedures and screening criteria, specialized care, any unique features to support the functioning of cognitively impaired persons or how staffing and treatment and care provided in the facility's BTR unit differed from that provided in the traditional assisted living unit.

Therefore, the facility failed to ensure that its single Uniform Disclosure Statement met the Department requirements for an Alzheimer's Special Care Unit Uniform Disclosure Statement.

STATEMENT OF DEFICIENCIE S AND PLAN OF CO RRECTION	(X1) PROVIDER/SUPPLIER/CUA IDEN TIFICATION NUMBER:	(X2) MULTIPLE CONSTRU CTION	(X 3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING:_____ B. VV1N_G _ _ _ _ _ _ _ _	07/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

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E3960	Continued From page 3	E3960		
E3960	.35 A1,2 .35 Resident's Rights	E3960		

.35 Resident 's Rights.
A. A resident of an assisted living program has the right to:
(1) Be treated with consideration, respect, and full recognition of the resident's human dignity and individuality;
(2) Receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant State, local, and federal laws and regulations;

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that care and services provided were adequate and appropriate.

Findings included:

At the time of the survey, the following was documented for Resident #5 for- :

A. I. At 7:15 PM, nursing notes recorded that Resident #5 was alert and responsive.

II. At 8 PM, nursing notes recorded that [redacted] was "unresponsive" and that [redacted] "eventually gain consciousness." "Vital signs were 84/48 , 51."

III. An undated and untimed entry at the top of a nursing note page that had the date- directly below the undated/untimed entry noted that "Resident became unresponsive again. 911 called and sent out to the ER."

IV. An incident report dated- noted that the Resident was "unresponsive" and transported via ambulance to the ER at 7:30 PM.

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	16AL492	A. BUILDING:_____ B. Vv1NG _____	07/21/2015

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E3960	E3960 Continued From page 4 The ALM related that all nursing notes were completed either by a registered nurse (RN) or a licensed practical nurse (LPN). The above demonstrate 1)a delay in calling 911 when Resident #5 initially became unresponsive; 2)an undated/untimed nursing note entry; and 3)time discrepancies between the nursing notes and the incident report for the above noted events. B. Resident #5's vital signs documented in the nursing notes for April 19, 2015 were blood , the delegating registered nurse/case manager's (DRN/CM) nursing assessment dated April 21, 2015, Resident #5's vital signs were blood pressure: 160/90, pulse: 62 and respirations: 18. Thus, a blood pressure reading of 84/48 and pulse of 51 were not within normal limits for Resident #5. Therefore, that facility failed to ensure that Resident #5 received the care/services appropriate to [redacted] needs in a timely manner.	E3960		
E4630	.41 A .41 General Physical Plant Requirements .41 General Physical Plant Requirements. A. The facility, which includes buildings, common areas , and exterior grounds, shall be kept: (1) In goodrepair; (2) Clean; (3) Free of any object, material, or condition that may create a health hazard, accident, or fire; (4) Free of any object, material, or condition that may create a public nuisance; and (5) Free of insects and rodents.	E4630		

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E4630	Continued From page 5	E4630		

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure that the Residents' environment was free of potential health hazards.

Findings included:

On July 20, 2015, between 11:40 AM and 12 noon, the following was observed in the facility's Alzheimer's/dementia unit (Bridges to Rediscovery or BTR):

I. No soap was found in the bathrooms of rooms 11, 12, 22 or 24.

11. No towels or face clothes were seen in the bathrooms of rooms 11, 15, or 22. The bathroom of room 12 had a face cloth on the assist rail for the toilet and a face cloth on the assist rail for the shower; however, there was no towel in this bathroom.

III. Staff #4 was observed assisting Resident #9 into [redacted] room (room #12) about 11:50 AM. Staff #4 was exiting this room with Resident #9 and had started to close the room door with her hand on the door's lever handle when the survey team and ALM started to enter this room. Staff #4 guided Resident #9 down the hallway ofthe unit while the survey team and the ALM entered room #12. Observation of the room's bathroom revealed NO soap and NO towel. About 12 noon, while this surveyor was in the room's bathroom, Staff #4 re-entered the bathroom to remove a soiled diaper. When she was asked how she washed her hands after changing Resident #9 when there was no soap in the bathroom, Staff #4 stated she was not finished. However, Staff #4 had exited the bedroom, touching the lever door

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E4630	Continued From page 6 handle prior to the survey team entering the bedroom . When asked how she would be able to dry her hands, Staff #4 indicated the dry washcloth on the assist rail for the toilet. IV. Staff #4's most current training in infection control was dated January 28, 2015. The instructor was the ALM who is a licensed practical nurse (LPN.) The documentation provided of this training was quiz of ten (10) questions which was not graded. Although Staff #4's file documented that she had received training in infection control, she did not demonstrate use of that knowledge on July 20, 2015 as far as the importance of thorough hand washing with soap to prevent spread of infections/diseases. Therefore the facility failed to ensure that residents and staff in the facility's Alzheimer's/dementia care unit (BTR) had soap available in four (4) out of five (5) bathrooms observed and had towels - or any linen to use to dry one's hands - available in three (3) out of five (5) bathrooms observed, thus creating a potential health hazard and risk of infection for residents and staff in the BTR unit.	E4630		
E4690	.42 C .42 Water Supply C. Hot Water Temperature. Hot water accessible to residents shall be blended externally to the hot water generator, by either individual point-of-use control valves of the anti-scald or thermostatic mixing valve type, to a maximum temperature of 120°F and a minimum temperature of 100°F at the fixture. This REQUIREMENT is not met as evidenced	E4690		

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E4690	E4690 Continued From page 7	E4690		

by
Based on observation, the facility failed to ensure that the hot water temperature range was between 100 and 120 degrees Fahrenheit at the facility.

Findings included:

l. On July 20, 2015 between 11:15 AM and 12:10 PM, the following elevated hot water temperatures in degrees Fahrenheit were recorded for readings taken in the residents' bathrooms:

Traditional AL Room #	Temperature
109	124
101	132
110	136
117	126
133	128
135	128
Resident Spa	126

Alzheimer's Unit Room # (Bridges to Rediscovery)	Temperature
12	126
15	124
22	124

Following the facility tour , the ALM called a maintenance worker from another facility who arrived at facility approximately at 2:35PM on July 20, 2015 to lower the temperature on the hot water heater. The ALM related that he had also called Magnolia Plumbing to request that someone come to the facility to adjust the hot water supply since the maintenance worker who lowered the hot water heater temperature was not a plumber. However, the plumber from Magnolia Plumbing could not come to the facility until the

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E4690	Continued From page 8	E4690		

next day (July 21st.) The ALM explained that in Janua ry, the Director of Maintenance for the facility had ended his employment with facility. The ALM further explained that another Director of Maintenance had been hired in June, 2015; however, that person had ended his employment with the facility after a three week period. No Director of Maintenance was employed by the facility at the time of the survey, the ALM noted and the most current hot water log the ALM had available was dated January 30, 2015. It documented hot water temperatures in residents' rooms ranging from 119 to 123 degrees Fahrenheit.)

II. On July 21, 2015 between 9:10 AM and 9:35 AM, the following elevated hot water temperatures in degrees Fahrenheit were recorded for readings taken in the residents' bathrooms:

Traditional AL Room #	Temperature
109	126
101	134
110	128

(Rooms 117 and 135 had hot water temperatures of 118 and 110 degrees Fahrenheit respectively on July 21, 2015 between 9:20 AM and 9:25 AM and thus were not elevated at that time. The Resident in room 133 was sleeping and the ALM did not have the key to the resident spa with him when the hot water readings were taken.)

Alzheimer's Unit Room # (Bridges to Rediscover)	Temperature
12	122

(Rooms 22 and 24 had hot water temperatures of 112 and 114 degree Fahrenheit respectively on

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE ZIP CODE
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E4690	Continued From page 9 July 21, 2015 between 9:30 and 9:35 and thus were not elevated at that time.) At approximately 10:05 AM on July 21, 2015, a plumber from Magnolia Plumbing arrived at the facility. He related that the facility's hot water heater had a 500 gallon tank and the he had lowered the hot water temperature on the hot water heater to approximately "130"degrees Fahrenheit which would then "mix" with cold water before it was sent out into the facility. Therefore, the facility failed to maintain the hot water temperature within the range required by the Department.	E4690		

Office of Health Care Quality

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	16AL492	A. BUILDING: _____ B. WING _____	C 06/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE. ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 000	Initial Comments On June 2, 2015 a complaint investigation was conducted at the above facility to assess the facility compliance with COMAR 10 07.14 Survey activities included review of records and interview with facility staff. Facility census on day of the survey was forty-nine (49) residents. Based on survey findings only in relationship to complaint# MD00091271 the facility was found to be non compliant with the regulations governing assisted living facilities, COMAR 10 07.14.	E 000		
E3330	B1,2 .26 Service Plan **B.** Assessment of Condition . (1) The resident's service plan shall be based on assessments of the resident's health, function, and psychosocial status using the Resident Assessment Tool. (2) A full assessment of the resident shall be completed : (a) Within 48 hours but not later than required by nursing practice and the patient's condition after: (i) A significant change of condition ; and (ii) Each nonroutine hospitalization; and (b) At least annually. This REQUIREMENT is not met as evidenced by: Based on review of records and interview with facility staff the facility failed to complete a full assessment on one resident within 48 hours after a significant change in condition and failed to update the service plan for one of one from sample size of one resident. Findings include:	E3330		

OHCQ

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X5) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING:_____ B. WING_____	C 06/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E3330	Continued From page 1 Resident # 1 was admitted to the facility with diagnoses which include Dementia. This resident is alert and oriented with periods of confusion and is dependent on facility staff for all activities of daily living. Review of the resident record on June 2, 2015 at 11:00 AM revealed out of the facility with a visitor, fell and was transferred to the hospital by the Emergency Medical Services. Continued review of the records revealed the resident sustained bruises to left knee and back of right arm and sustained a laceration to the right side eyebrow and received five stitches. returned to the facility on- at 8:00 PM and was placed on 1:1 nursing monitoring. Review of the resident service plan revealed the last updated service plan was dated April 15, 2015. Review of the Delegating Registered Nurse resident assessment revealed the assessment was not updated. Further review revealed despite the resident significant change in condition the ORN did not complete a reassessment and update the resident service plan after 40 days of the change.	E3330		

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRU CTION	(X3) DATE SURVEY COMPLETED
	16AL492	A.BUILDING:_____ B.WING_____	C 05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE. ZIP CODE
HEARTFIELDS AT BOWIE	**7600 LAUREL BOWIE ROAD BOWIE, MD 20715**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E OOOI Initial Comments		E 000		

On May 1, 2015 an unannounced complaint in vestigation was conducted at the above facility to assess the facility compliance with COMAR 10.07.14. Survey activities included a tour of the facility and observation, review of records and interview with residents and facility staff.

The census on the day of survey was fifty (50) residents.

Based on survey findings only in relationship to the allegations of the complaint# MD00090507 the facility was found to be in compliance with the regulations governing assisted living facilities, COMAR 10.07.14.

OHCQ

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

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16AL492	A. BUILDING: _____ B. WING _____	C 03/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS . CITY, STATE. ZIP CODE
HEARTFIELDS AT BOWIE	7600 LAUREL BOWIE ROAD BOWIE, MD 20715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACHDEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYINGINFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACHCORRECTIVE ACTIONSHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
E 000	Initial Comments On March 20, 2015 an unannounced complaint investigation was conducted at the above facility to assess the facility compliance with COMAR 10.07.14. Survey activities included a tour of the facility and interview with facility staff. The census on the day of survey was forty-seven (47) residents. Based on survey findings only in relationship to the allegations of the complaint# MD00089199 the facility was found to be in compliance with the regulations governing assisted living facili ties, **COMAR** 10.07.14.	E 000		

OHCQ

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

STATE OF 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. **16AL492-I**

lssued to: Five Star Quality Care MD, LLC
T/A fl artfi¢ld s At Bowie
760() Laurel Bowie Road
Bowie, MD 20715-I075

Type of Facility or Cornrnunj Program:	Number of Be<.is:	Level of Care:
Assisted **Living**	**52**	3

TWO YEAR LICENSE

Date Issued: October 24, 2016 Expiration Date: October 23, 2018

Renewal License - Replaces License #16AL492-H

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, Title 19 § 1801, et. seq., Annotated Code of Maryland, including all applicable rules and regulations promulgated there under. This document is not transferable.

Patricia Tomsko May MD

Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

f(f:CEIVED

STATE OF MAR'il.AND
DEPARTMEITT OF HEALIH AND MENTAL HYGIENE (OHMH)
OFFICE OF HEALTH CARE QUALITY (OHCO)

OCT l=JLZ.flWv4113
DHMH FoonALAPP,1.1

ASSISTED LIVING
APPLICATION FOR LICENSURE

Office of
Health Ca1e Quadty

1. GENERAL INFORMATION

CHECK TYPE OF APPLICATION

D Initial j [j] Renewal j D Change of Ownership (specify effective date) j D other Change (specify type)

LICENSE NUMBER {if applk::able) 16AL492-H	WEBSiTE (if appllc3ble) www.heartfieldsassiste dlivingatbowfe.com
LEGAL AGENCY NAME Five Star Quality Care-MD, LLC.	TRADING NAME (OBA) HeartFields at Bowie
E-MAIL ADDRESS adcampbell@5ssl.com	PHONE NUMBER 301-805-8422 FAXNUMBER 301-805-8622
BUSINESS ADDRESS (physica location) 400 Centre Street	MAILING ADDRESS (if cfrfferent) 7600 Laurel Bowie Road
NUMBER, STREET	NUMBER, STREET
CITY Newton STATE **MA** ZIP 02458	CITY **Bowie** STATE **MD** ZIP **20715**

Does the owner, corporation, or partnership operate and manage the assisted living program? Yes LJNo
(identify the management structure andIts relationship to the business owner)

NUMBER OF RESIDENTS CURRENTLY SERVED	NUMBER OF BEDS REQUESTED	LEVEL OF CARE REQUESTED
52	52	01 02 [j]3

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

NAME OF MANAGER Aaron Campbell	PHONENUMBER (301) 805-8422	CELL NUMBER (443) 421-0282
HOME ADDRESS (number, street) 1019 Meherrin Court	CITY Glen Burnie	STATE ZIP MD 21060
NAME OF ALTERNATE MANAGER Patricia Coley	PHONE NUMBER	CELL NUMBER **(240)498-5339**
HOME ADDRESS (number, slreet) 4001 Buck Creek Road	CITY Temple Hliis	STATE ZIP **MD 20748**
NAME OF OELEGA TING NURSE (ON) Patricia Coley	PHONE NUMBER	CELL NUMBER (240) 498-5339
HOME ADDRESS (number, street) 4001 Buck Creek Road	CITY Temple Hills	STATE ZIP **MD 20748**
DN'S LICENSE NUMBER	EXPIRATION DATE OF ☐N'S LICENSE	

Is your 1acl11ty planning to operate, or currentiy operating, an 'Alzheimer's Special'Care Unit or Program?" D No
- Ii! Yes (refer to the instruction guide for details on submitting your program.,description)

2. FEES

To determine the amount of 1he **non-refundable** license fee and accepted methods of payment, refer to 117e instruction guide.

YEE ATTACHED? Yes

i;oW,NiRSH!P{Type of bu in.e$f\ organiz1)tioQ ofdisclosiog entify)

SOLE PROPRIETORSHIP | PARTNERSHIP | x CORPORATION

NAME	ADDRESS
Five Star Quality Care	400 Centre Street, Newton, MA 02458

If P/\R1/\I.EJ{$HIP OR CORPORATION,

PARTNER, OFFICER, DIRECTOR 0 STCCKHbtlOER INFORMATION AND PERCENTAGE OWNED IF.25%'0R MORE:

NAMfAND TITIE	JMIL	f'lHONE flUMBgR	'ADDRESS	,OW ED·i

IF CORPORATION:

DATEOFCHARIER | DATE OFINCORPORATION | FEIN NUMBER

NAME OF PRESIDENT	PHONE NUMBER	CELL NUMBER
ADDRESS (number, street)	CITY	STATE ZIP

4. BACKGROUND

1. Has the applicant, owner, or managerial staff ever had a license, permit, or certificate to provide care to third parties that has been denied, suspended, or revoked? i] No D Yes (explain)

2. Does the applicant currenHy hold, or has the applicant previously held, any license or certification for the operation of a health care facility or similar health care program? D No lii Yes (explain)

3. Does the owner, applicant, manager, alternate manager, other staff, or any household member have a cMminal conviction or other criminal history? Ii] No D Yes (explain)

5. WORKERS' COMPENSATION

Do you have any employees? ■ Yes ☐ No

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

POLICY NUMSER	BINDER NUMBER	
L□S4055032	PS4055033	
INSURANCE COMPANY	EFFECTIVE DATE	EXPIRATION DATE
Safety National Casualty Corporation	June 15, 2016	June 1, 2017

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

6.AFFIDAVI.T

I solemnly affirm under the penalties of perfury and upon personal knowledge that the contents of the foregoing application are1rue. I understand that the falsification of an application for a license may subject me to criminal prosecution, civil money penalties, and/or the revocation of any license issued to me by theDHMH. In addition, knowingly and Willfully failing to fully and accurately disclose therequested Information may result In denial of a requesUo.J:iecorne.license<j,or,wheretheenfityalreadyislicensed,arevocatio{},QfJllQUicense.

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

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

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

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

SIGNATURE OF APPLICANT	TITLE '?,,. ej-' <!.eo	DATE *JO.'l7 Ile*
SIGNATURE OF APPLICANT	TIT!!=.	DATE
SIGNATURE OF APPLICANT	TITLE	DATE
SIGNATURE OF APPLICANT	TITLE	DATE

FOR OFFICE USE ONLY

LICENSE NUMBER | FEE 350 00 | CHECK NO. 212264 | CHECK DATE 10 8 16

Maryland Assisted Living Program

Uniform Disclosure Statement

What is the Purpose of the Disdosure Statement?

Thepurpose of the Disclosure Statement is to empower consumers by describing an assisted living program's policies and services In a uniform manner. This format gives prospective residents and their families consistent categories of information from which they can compare programs and seivices[1].

It is important to note that the Disclosure Statement Is not intended to take the place of visiting the program, talking with resldents, or meeting one-on-one with staff. Nor is the statement a binding contract or subsHlute for lhe Resident Agreement. Rather, ii serves as additional information for making an informed decision about the services provided In each program.

If you have any questions about any issue raised In the Dlsdosure Statement or In the Resident Agreement provided by an assisted living program, please seek darification rrom that program's manager or admlnlstrator.

What is Assisted Living?

Assisted living is a way to provide care to people who are having difficulty living independently. Assisted living providers furnish a place to live, meals, and assistance with daily activifies such as dressing, bathing, eating, and managing medicaHons. Assisted living programs also tend to have a less institutional look than nursing homes. However, lhese facilities are not as highly regulated *by* the State as nursing homes. There area wide variety of assisted living programs in Maryland. They range from large, corporate-managed facilities where hundreds of people live in their own apartments to small, private homes.

Assisted living programs may differ in many ways including, but not limited to: size, staff qualifications, services offered, location, fees, sponsorship, whether they are freestanding or part of a continuum of care, participation In the Medicaid Waiver, abflity to age in place, and visiting hours. Therefore, consumers should tJy to have a general Idea of what type of setting, services, and price range lhey may want before conlactlng an assisted living program, as well as having questions prepared to ask the program manager or administrator. Consumers may find the Maryland Department of Aglng's publication entiUed, 'Assisted Living in Maryland: What You Need to Know," helpful when they are contemplating assisted llving. The publication may be downloaded from the Department of Aging's Website. (http://www.mdoa.state.md.us/documentslALGulde_002.pdQ

In addition, the Office of Health Care Quatity (OHCQ) encourages consumers to verify the licensure status of any assisted living program that they are considering. A list of licensed assisted living programs is available online. (http://www.dhmh.marytand.gov/ohcq/about_ohcqAicensee_directory.htm)

Where can I **find the Assisted** Living **Licensure Standards?**

The Assisted Living Licensure Standards are found in the Code of Maryland Regulations (COMAR) 10.07.14, available at public libraries, onllne at http://www.dsd.state.md.us/comar/, or ordered for a small fee from the OHCQ, A copy of the most recent survey report of an assisted living prowa may be obtained from the program's manager or administrator.

[1] Assisted Living providers are not required to provide all of the services listed in the Disclosure Statement-regulatory requirements may be found in COMAR 10.07.14.

1) Assisted Living Program Contact Information:

Fadlity Name Heartfields at Bowle	
License No.16AL492-H	No. of Licen Beds ey2 Level of Care at which Facilily is Licensed 3
Address (Street, City, State, Zip)7600 Laurel Bowie Road **Bowie,** MD 20715	
Phone Number 301-<'305-8422	Fax Number301-805-8622
E-Mail Address (optional) adcampbell@5ssl.com	Operator/Management Company 5 Star Senior Living
Manager Aaron Campbell	Contact Information adcampbell@5ss.lcom
Delegating Nurse Patricia Coley	Contact Info ation pcoley@5ssl.com
Alternate Manager Pabicia Coley	Contact IntormaUon pcoley@$ssl,com
Completed By Aaron Campbell	TitleExecutive Director Date Completed 07/13fl015

2) What sources of payment are accepted?

Assisted living programs differ in what types of sources they may accept for payment e.g. private insurance, Medicaid, private pay, SSI/SSDI, etc. What sources of payment are accepted at this program?

Private Pay. Long Term Care Insurance and Veteran's Benefits may be used, payment must be made by the resident or responsible party.

3) What are levels of care?

The levels of care correspond with how much assistance residents need. The level of care designatlon, therefore, reflects the complexity of the services required to meet the needs of a resident. The State of Maryland recognizes three levels of care, and they are as follows: Level 1 is low level of care required, Level 2 is moderate level of care required, and Level 3 Is high level of care required.

A resident's level of care is determined by the Resident Assessment Tool, which collects essential infom1aUon about a resident's physical, functional, and psychosocial strengths and deficits. There are two components to the assessment tool - a Health Cara Practitioners Physical Assessment, lo be completed or verified by a health care practitioner, and the Assisted Living Manager's Assassmenl to be completed by the Assisted Uvfng Manager or designee. A residenfs score on the assessment tool detem1ines his/her level of care (Level 1 = a total score of 0-20; Level 2 = a Iota! score of 21-40; and Level 3 = a total score of 41 or higher).

Some assisted living programs may have elected to develop more than three levels of care. If an assisted living program has more than three levels of care, please describe tt:ie.l vels of care and how they correlate to the ihree levels of care recognized.by; . the State. In addition, Include program charges for, each level of care.

Explanation: (You **may** attach miit•ri•I• •• n..,.;,,.iy)·' 1-1ean Fiold, olfers **thne** (3) **1e.,,,1,** of plu, • base leYeL Nunlni **.,__.,...,n, ore co,npk:u,,JWnt** both ti,• mN•.,eum.,,t tool and tfle Five Stal' UkJ,mont tool in otdet to decennlN how mllCh usl,wu:e "1th ADL's a resident **wtl ..-1,**

4J *What is a Resident Agreement?*

The resident agreement is a legal contrac obligating a consumer to provide payment in retum for services to be provided by the assisted living program. An assisted living program will provide a consumer with a Resident Agreement to review and sign prior to move-in. Prospective residents should feel free to request a copy of a sample resident agreement at any time.

The resident agreement is required by regulation to include, at a minimum, the infom,ation provided in COMAR 10.07.14.24(0) and 10.07.14.25(A), such as: the level of care the program is licensed to provide, a list of services provided by the program, an explanation of the program's complaint or grievance procedure; admission and discharge policies and procedures; obligations of the program and the resident or 1he resident's representative wiih regards to financial matter&.-4landling resident finances, purchase or rental of essential or desired equipment; arranging or contracting for services not covered by the resident agreement; rate structure and payment provisions; identification of persons responsible for paymen notice provisions for rate increases; billing, payment, and c:edit polices; and terms governing the refund of any prepaid fees or charges in the event of a resident's discharge or termination of the resident agreement.

SJ What Services are Provided?

Consumers should expect assisted living programs to provide clear infonnation regarding services and fees. Some programs *may* charge fees for services based on the resident's assessed level of care, while others may provide an •a la carte• menu of services. Consumers should understand what is included in the base monthly rate, what services require an additional charge, circumstances under which fees may increase, and the refund policy. Below is a chart to help consumers better compare assisted living programs. This chart is not all-Inclusive and providers may offer more or fewer services than listed below.

Offered Yes	Offered No	Service	Included in Base Rate for Level of Care (yes/no)	May be Purchased Separately. If so, please indicate cost.
Nursing and Clinical **Care:**				
	U	24-Hour Awake Staff·,Including Awake Overnight Staff- .	yes	
181	u	Nursing Review Every 45 Days (Required by COMAR)	yes	
	U	.On-siteLicensed Nursing I Hours/Week)	yes- 24/7	
	□	Physician Services	yes	
	U	Bladder Incontinence Care	yes	
181	u	Bowel Incontinence Care	yes	
u		Catheter Care	n/a	
[8J	LJ	Consultant pharmacist medication review (required in some cases)	yes	
	u	Diabetes Care	no	
	LJ	End of Life Care	no	
	LJ	Home Health	no	
[8J	u	Hospice Care	no	
[8J	□	Incontinence Products	no	
[8J	u	Infection Control Materials (e.g., gloves, masks, etc.}	no	
181	LJ	Nubitional Supplements	no	
[8J	□ □	Service Plan and Frequency (Required by COMAR at least every 6 months)	yes	
		Temporary use of wheelchair/walker	yes	

Offered Yes	Offered No	Service	Include charge in Base. Rate of Level of Care (Y)	May be Purchased. If applicable, please indicate cost
Personal Care:				
	u	Assistance with bathing	no	
		Assistance with dressing	no	
u		Assistance with handling money	NIA	
		Assistance with incontinence	no	
u		Assistance with preparing meals	*yes*	
[8J		Assistance with shopping for food or personal items	yes	
	u	Assistance with toileting	yes	
		Companion Services		
		Housekeeping	yes	
	u	Mobility/Transfer Assistance	no	
		Personal Care Items	no	
Environment:				
	Li	Activities program (_ days per week), specify programs or attach calendar.	yes	
l25J		Alcohol Consumption	yes	
		Barber/Beauty Shop	no	
	u	Cable TV	no	
	u	Fire Sprinklers (_ In all **areas** or _ in some areas), specify:	yes	
u		Internet Access	WiFi	
	LJ	Linens/Towels	yes	
u		Chair Glide System	no	
D	[8J	Dry Cleaning Services	no	
LJ		Elevators	no	
	Li	Emergency Call System	*yes*	
l25J	LJ	Emergency Generator	yes	
	LJ	Fire Alarm System	yes	
u		Automatic Electronic Defibrillators (AEDs)	no	
r8l		Handrails	yes	
	u	Personal Laundry	yes	
	L J	Personal Phone	yes	
(83		Pets Allowed, specify:	no	
181		Ramps	yes	
	LJ	Security Services, specify:	yes	
		Smoking	yes	
l2!J	LJ	Secured Areas	yes	
	u	Sprinkler system	yes	
	LJ	Transportation, specify	yes	
(83	☐	V1sitation, specify hours and include the facility's policies and procedures	yes	

:: ', Offer q		Se .i ;'	•-Includetl in Base Rate tor. Leyei of Care Yeslop)	:: aytiePr, tia e,q· p1rately. If SQ pl. ase indica Gos
i• Yes	No			
Environment: (Continued)				
12$1	LJ	Volu\He r SetvicGs specifyand include the facility's policies and procedures	yes	
IXI	I	Wander Guard or s!milar system, specify:	yes	
Dietary:				
	u	Meals(per day & snacks) (COMAR requires a minimum of 3 meals per day & additional snacks)	yes	
!XI		Special Diets, specify:	yes	
IX]	I	Family or Congregate Meals	no	$5-$15 per person
Pharmaceuticals/Medications:				
		.O reble, ical Equipment, soecifv:	oo	hysical therapy
>		Medication Administration	no	
		Medication Injections	no	
		Phamiaceuticals	no	
		Self Administration of Medlcaijons Permitted	yes	
		Use of Outside Pharmacy Permitted	yes	
		Use of Mail Order Pharmacy Permitted	no	
Soeciallzad Care or Services:				
		Behavior Management: Verbal Aggression	yes	
		Behavior Management: Physical Aggression	yes	
		Dementia Care	yes	
		Intravenous Therapy	no	
		Mental Health Supports and Services, specify:	no	
	x	OstomyCare	no	
		Oxygen Administration	yes/no	
	u	Special careUnits, Iftherearead ditional charges for thistypeof care, please specify cost difference as well as how those services differfrom1heservicesprovided Intherestoflheprogram.	no	
jg]		Services for persons who are blind	yes	
LJ		Staff who can sign for the deaf	no	
LJ	l2S.I	Bilingual Services	no	
		Tube Feeding	no	
12$1	LJ	Wound Care	no	

Are the resident, resident's representative, or family members involved in the service pjanninJ process? t8J Yes D No

Explanation: (optional) Initial JUSeSSment, a, need, clange, PRN and 6 mondu • famip meeting isoffered

Is' ttie service plan reviewed with the residen resident's reoresentalive. or family 'members? (8J Yes O No

Explanatlon;(optlon•I) fnldal assessment,,..n•d• dlange, **PKN** and *tN<ry* 6 month, a family meed 31, otr•red

Who assists with or administers medications? [Check all which apply}

181 Delegating Nurse/Registered Nurse jg) Licensed Practical Nurse **D** Medication Technician D Olher (specify}:

6) What are the criteria for discharge or transfer?

The following is a list of situations that may necessitate the termination of the resident agreement and the transfer or discharge of a resident from an assisted living program. Consumers are encouraged lo inquire about an assisted living program's policies and procedures in the event that a resident must relocate. This list Is not all-inclusive and criteria will differ depending upon the assisted living program's ability, to µr0\"idi.l oortair.h!Yf.l&S of care. All transfers and discharges must comply-witM,lar)'.l:XHJ regulatory requirements, including notice requirements, and tenns of 1he Resident Agreement.•

Criteria/Factor which may:	Cause (temporary) transfer	Cause (manenl) dischijrge	Require Ille use ofexternal resources
Medical condition requiring care exceeding that of which the facility determines it can safely provide			
Unacceptable physical, verbal, or sexual behavior			-
Medication stabilization			
Danger to self or others			
Inabilicy to toilet	u	u	u
Non-ambulatory			
Inability *to* eat/tube feeding	u		u
Must be hand fed	u	u	u
Inability lo walk/bedfast			
Others:			
Mental health issues, specify:			u
Mobility changes	u	u	
Needs skilled nursing care			u
Requires sitters		lo!	
Medication injections	u	u	u
Behavior management for verbal or physical aggression		lcJ	**u**
Bladder incontinence care	u	u	□
Bowel incontinence care		u	
Intravenous (IV) therapy		lcJ	**u**
Level of care change			
Moderate or advanced dementia, specify:	u	u	
Memtat Health lssuas (from above- conditicns requiring aggressive rreatmen		lcJ	u
Others- from above- Wound care			lcJ
	u	□	□
		u	u

'Under Maryland'Regulatlons an assisted living program may not pro'lide services to an Individual who11t tho ttms-0!Initial oomlsslon, a.s established by Iha lnitlalassessmen requires: (1) More thanintermitt1mtnurning care; (2) Treatment or stage three or stage-follrskin ulcers; (3) Vtmtilator services; (4) Skilled monitoring, testing, and aggressive adjuslment of modicatloos and trealments where there is the presence of, ormk ror, a Huctuating acute condition; (5) Monitoring of a dlronlc medlcal condltlon that Is not controllable through readily available medications and treatments; or (6) Treatment for a d!sease or condition whichrequiresmorelllancontactIsolation. Exceptions totheconditions listedabovearepro vided forindividuals whoareunderthecare of alicensedgeneral hospice program.

Who makes the residentdischarge or lransfer decision?

18] Assisted Living Manager
18] Delegating Nurse
D Registered Nurse
18] Other (specify)managemenl team

Do families have input into the disch rgl;) q(1Xfl . ffff [! .?" **181** Yes D No

Is there an avenue to appeal the discharge or transfer decision? **181** Yes D No

Explanatlon:(optiOfl Hay Clll corporate s Stat uallty c.,...Gold star line

Does the assisted living program assist families inmaking discharge or transfer plans? **[81** Yes D No

Explanatlon:(optionoJ) wm u,in **families with transfer** io **anotller Al., IL, AU, Slcflled, ere**

7) What are the requirements for staff training?

COMAR requires that assisted living programs provide initial and annual training for the alternate manager and staff in: (a) fire and life safety, including the use of fire extinguishers;(b) infection control, including standard precautions, contact precautions, andhand hygiene; (c) basicfood safety; (d) emergency disaster plans; (e) basic firstaid by a certified firstaidinstructor; and (ij cognitiveimpairmentandmentaliUnesstraining. Staffmusthave training or experience in: (a) the healthandpsychosocial needs of the population being served; (b) the resident assessment process; (c) the use of service plans: and (d)resident rights. A sufficient number of staff must also have initial and ongoing training in CPR !raining from a certified instructor. Consumers are encouraged totalk lo the assisted living program manager about sources of staff training and their qualifciations.

COMAR requires that assisted living programmanagers have sufficient skills, training, and experience to serve the residents In a manner that is consistent with the philosophy of assisted living. Managers must ha'le 'lerifiable knowledge in: (a) the health !l1d psychosocial needs of the population being served; (b} the resident assessment process; (c) use of service plans; (d) cuing, coaching, and monitoring residents who self-administer medications with or without assistance; (e) providing assistance with ambulation, personalhygiene, dressing, toileting, and feeding; and (Q resident rights. Managers must receivelnlHal and annual training in:(a) fireandlife safety;(b)infection control,includingstandard precautions;(c) emergency disasterplans:and(d) basic food safety. Managers are required to have initial cerlificaUon and recertification in: (a) basic first aid by a certified first aid Instructor; and (b) basic CPR by a certified CPR instructor.

COMAR requires that assisted living program managers of programs licensed for fivebeds or more have completed an 80-hour manager's training course. Some managers are exempt from this requirement

Some assisted living programs may elect torequire training for staff, managers, and alternate managers beyond these requirements
Additional training provided: Five Star Quality Care policies and procedures, HIPPA training, BTR training and Dementia training per state requirements.

BJ What is-t he'ass isted living program's staffing pattern]...:

COMAR requires assisted living programs to develop a staffing plan that inciudes on-site staff sufficient in number and qualificatlons to meet the 24-hour scheduled and unscheduled needs of the residents. The delegating nurse, based on the needs of a resident, may issue **a** nursing order for on-site nursing.

SHIFTS (Enter the hours of each of your facility's shifts)	NUMBER OF STAFF PER SHIFT PER DAY							
	RN	LPN	CNA	Medication Tech.	Activity Workers	Non-Licensed Assistive Personnel	Other Workers	Awake Overnight
7am-3pm	1		3-4 may be C.N.A. or Non-C.N.A.			3-4 may be C.N.A. or Non- C.N.A.	7	
3pm-11pm & 12P-8P			4 May be C.N.A. orNon-C,N.A. 2 ma-y· be C.N.A. or non-C.N.A.			4 Maybe C.N.A. or Non-C.N.A. 2 *may* be C.N.A.or Non-C.NA.		all
11am-7pm								
11pm-7am			2may be **C.N.A.** or Non-C.N.A.			2may be C.N.A. or Non- C.NA		3-aN awako staff
8am/9am-8prn							Mgmt/desk staff-8	

If staff do not work on a per-day basis, indicate the onsite hours per month.

RN	LPN	Physician	Social Worker	Pharmacist
N/A	N/A	Monthly	N/A	Quarterly

Explanation: Pharmacist reviews resident charts quarterly.

9) How do I file acompklint?

Under Maryland regulations, assisted living programs are required to have an internal complaint or grievance procedure. An explana on of the assisted living program's Internal complaint or grievance procedure must be included in the resident agreement. Consumers should review this infon:nation and make sure that they understand how the internal complaint or grievance procedure opear,to,o, Gonsumers sho ld direct any questions about the internal procedure -to{l:ie.Qs:Jisted living program's manager or admniistrator.

Consumers may also report concerns or file a complaint regarding an assisted living program to the Office of Health Care Quality. Complaints may be registered over the phone or through the OHCQ Web site. Complaints may be anonymous. For more information regarding filing a complaint, please visit the Office of Health Care Quality's Web site at http://www.dhmh.state.md.us/ohcq/faq_help/file a_complainl hlm or call (410) 402-8217 or 1-877402-8218.

Maryland Department of Health and Mental Hygiene-Office of Health Care Quality
Spring **Grove** HospltaJ Center-Bland Bryant Building
55 Wade Avenue
Catonsvllle, Maryland 21228
Phone: (410) 402-8000 Toll **Free:** 1-877-402-8218
www.dhmh.!t • .,,..d.·:s/Dh.cCf.,;c:1,.,

STATE OF MARYLAND
Department of Assessments and Tax,ation

I, PAUL B. ANDERSON OF TIIE STATB DEPARTMENT OF ASSESSMENTS AND TAXATION OF THE STATE OF MARYLAND, DOHERBBY CERTIFY THAT THE DEPARTMENT, BYLAWSOFTHE STATE, IS TIIE CUSTODIAN OF TIIE RECORDS OF TIIIS STATE RELATING TO THE FORFEITURE OR SUSPENSION OF CORPORATE CHARTERS, OR TIIE RIGHTS OF CORPORATIONS TOTRANSACT BUSINESS IN THIS STATE AND THAT I AM THE PROPER OFFICER TOEXECUTE THIS CERTIFICATE.

I FURTIIER CERTIFY THAT FSQ,1NC., QUALIFIED OCTOBER 28, 2002, IS A CORPORATION . DULY 1NCORPORATED AND EXISTING UNDER AND B:Y;SIRTUH.OltTHE LAWS OF THE STATE OF DELAWARE AND THE CORPORATION HAS FILED ALL ANNUAL REPORTS REQUIRED, HAS NO OUTSTANDING LATE FILING PENALTIES ON TIIOSE REPORTS, AND HAS A RBSIDENf AGENT. THEREFORE, THE CORPORATION IS AT TIIE TIME OF1HIS CERTIFICATE IN GOOD STANDINO WITHTIIISDEPARTMENT AND DULY AUTHORIZED TOEXERCISE ALLTHEPOWERSRECITEDIN ITS CHARTER OR CERTIFICATE OF INCORPORATION, AND TO TRANSACT INTERSTATE, INTRASTATE AND FOREIGN BUSINESS 1N MARYLAND.

IN WITNESS WHEREOF, I HAVE HEREUNTO SUBSCRIBED MY SIGNATURE AND AFFIXED THE SEAL OF THE STATE DEPARTMENT OF ASSESSMENTS AND TAXATION OF MARYLAND AT BALTCMORE ON nns TTJLY 27, 2012.

Paul B. Anderson

Paul B. Anderson
Charter Division

301 West Preston Street, Baltimore, Maryland 21201
Telephone Batto. Metro (410) 767-1340 I Outside Ba/to. Metro (888) 246-5941
MRS (Maryland Relay Service) (800) 735-2258 TT/Voice
Fax (410) 333-7097

crblnlc

R774447

ACORD@

CERTIFICATE OF LIABILITY INSURANCE

DATE (MI,I/DDIYYYY)
8/3/2016

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMA LY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER($), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If tho certificate holder l11 an ADDmONAL INSURED, the pollcy(les) must be endorsed. If SUBROGATION IS WAIVED, subJact to th& tenns and conditions of the policy, c:ertaln policies may require an endorsement. A statement on this certificate does not confer rights to the **certificate** holder In lleu of such endorsementlsl.

?FIOOUCER Willis Ins Serv of Georgia, Inc. 5 Concourse Pkwy NE 18th F!oor Atlanta GA 30328	S CIT Yolanda!i?u.coi PHJ?ttr •j• 404-224-30QQ t!'! L . yolanda.pos1ell@wllls.com	I f 404-224-5001
	INSURI:RISI AFI'ORDING COV!:RAG.E	**NAJCt**
	1NSURERA ,Safetv National Casualtv Corooratio	15105
INSURED Five Star Quality Care, Inc. and Its Subsidiaries 400 Centre Street Newton MA 02458	INSURER B : INSURER c: 1119URI!RD: INSURERE: INSURI!R P:	

TIVI..AaeiEs · . - "• ." .... CERitFICATE **NUMBER·** 307260544 . REVISION **NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BB.OW HAVE BEEN ISSUED ro THEINSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. N01WIT1-ISTANDING *AfN* REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH nus CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

iM	TYI'!! OF INSURANCE	1119D wvn	POLICYNUMBBR	r!..OM	, :lli\	LIMITS
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	Af>N P!IOPRJETOR/PARTNERIEXECI/TIVE OFFICER/MEMBER EXCLUDED? (Mandatory In NH) NIA ☐					E.L DISEASE· EA EMPLOYEE $1,000,000
	grs54"o" '5PERATIONSbelow					E.LDISEASE- POLICYLIMIT $1,000,000

DESCRIPTION OF OPERATIONS/ LOCATIONS /VEHICLES (,1,CORD 101;AddlCSonal Romarks Sch•dulo, **may** bo **attact,od** If **mor111PACa** l1 roqulred)

CERTIFICATE HOLDER

Evidence of Coverage

CANCELLATION

SHOULD ANY OF rne ABOVE DESCRIBED POLICIES BE CANCfLLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

&&R7';te

Maryland State Department of Health and Mental Hygiene
Prince George's County Health Department

PERMIT

T , Oper te a High HACCP Priority Food S rvice .Facility

This Permit Has Been Granted to:

RHONDA THOMAS
FIVE STAR QUALITY CARE INC
7600 LAUREL BOWIE RD
BOWIE, MD 20715

Tooperate a Food Service Facility Trading as:

I-IEARTFIELDS ASSISTED LIVING

PRINCE GEORGE'S COUNTY FOOD FACILITY ID NUMBER: 2547
7600 LAUREL BOWIE RD
BOWIE, MD 20715

THIS PERMIT IS GRANTED PURSUANT TO CODE OF MARYLAND REGULATION I0.15.03 AND/OR, SUBTITLE 12 OF THE PRINCE GEORGE'S COUNTY CODE AND IS SUBJECT TO ANY AND ALL STATUTORY PROVISIONS INCLUDING ALL APPLICABLE RULES AND REGULATIONS PROMULGATED THEREUNDER.

Expiration Dute	Pe1·mit Number
September 30, 2017	35007-2014-02

Van T. Mitchell
Secret111y 1Jf/11111/tl, 1111d Ml!flta/ llygie11e

P,-i11c11 George's County Health Ofjicer

NOT TRANSFERABLE· POST IN A CONSPICUOUS PLACE
DHi'vl‡H JOO· 20 (R vised)

PGCHD EH (3/ 1 5)

rRINCE GEORGE'S COUNTY, MARYLAND
FIREIE ,HS DEPARTMENT. FIRE PREVENTION UNIT
FIRE SERVICES BUCLDING
6820 Webster Street
Landover Hills, MD 20784
301-583«1830

CORR EC; M O N ORDER

FOLLOW-UP APPOINTMENT DATE: ___/___/____ (1m DICE) (2 Iml Cl) (lrn IfflCi)

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lue of Manager ACU("av-. WI Elelge.llcy FtlQl8 lo,(_)__ _

Jue of oner [redacted] Elergellt:y POOne lo,(___)___ ___

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SECTION

RE-INSPECTION CONDUCTED AT THE ADDRESS ABOVE
AND ALL PREVIOUS VIOLATIONS HAVE BEEN CORRECTED
STRUCTURE FOUND TO BE IN COMPLIANCE WITH
SUBTITLE 11 & NFPA LSC 101 AT THIS TIME.
OK to license.

* Approved *

2016 ANNUAL INSPECTION

* PLEA.SB SEB RBVBRSB SIDB -

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For Fire or Eaergency Allbulance Dial 911

P.G.C.FORM #150 (JlEV.5/06) SlPI.CO\IPIIS.2\IIC

PRINCE GEORGE'S COUNTY, MARYLAND
FIRE/EMS DEPARTMENT· FIRE PREVENTION UNIT
FIRE SERVICES BUILDING
6820 Webster Street
Landover Hills, MD 20784
301-583-1830

CORRECTION ORDER

FOLLOW-UP APPOINTMENT DATE: ___/___/___ (11tmcs, f2 111 mrta) (J1d ma)

1Jaa Group ________________ Drtt· o - : Y/-y

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SECTION

These premises are approved to continue to operate as an Assisted Living Facility for Fifty-two Beds

* PLEASE SEE REVERSE SIDE ~

Received by: [signature] Issued by: K. Garcy

Title: Asst Facilities Mgr / Five Star Quality Care Inc. Title: Engr III Contact Phone No. 301-583-2288

For Fire or Emergency Ambulance Dial 911

P.G.C. FORM #150 (REV. 5/06) SAFE.CO\MPWS.2\BMC

STATE OF MARYLAND

DEPARTME T OF HEAi /r e.· AND·MENTALHYGIENE

OFFICE'OF HEALTH CARE QUi\.Lll'Y. . .

SPR.ING GROVE CENTER
BLAND BRYANT BUILDING
,cf' 55⟨WAJ.)E AVENUE
CATONSVILLE, MARYLAND 21228

License No. **16.AL492-H**

Issued to: Fiye Stai °QU:iility re-MD, LLC
TIA Me.w:tmHdsA Bowie
7600:t aurel Bowie Road
Bowie, rvm 20715 1075

Type of Facility or C::Ommt1)1Program:	Number of Beds:	Level of Care:
- **sisted Living**	52	3

'fWO YEAR LICENSE

Dat Issued; October 25, 2014 Ei<.piratlon Date: Octobet· 24, 2016:

Renewal License - Replaces License #16AL492-G

Au'thority to operate in this tate is W: , te! fo the ahoviH:ntity pursuant to The Health-GeneraiArticl . Title 19 § 1801, CL ., seq.,.Annotated Cod¥ of Maryland, foe ding all applicable mies and reg11la!ions promulgntt:!i thcre'tinder. This docwnent is not tr;msferilble.

Patricia Tomasko May, Mot

Dii'ector

Falsification of a license shall uh·ecfthe er etrator to ci-iminal rosec.11tian and the {m osition a . civil mes.

k t: CEi'VED

OCT O 2 iuii

Office of FQflll 11IH14/1J

H ,, .. ,"!Q cW{y1m1 M.Att.:.L!.

STATL. OF I.IAll'ILANP
DEPARTMENT OF HEAi.11-IAND MENTAL k'fGtE.NE (DHMH)
om:1 OF HE.Al.TH CARE QUALITY (OHCOI

ASSISTED LIVING

., . - -J;.. APPLICATION FOR LICENSURE

1. GENERAi.. rNFORMATION

CHECk TYPE OF APPUCATION

D Initial Ii]Renewal D Change of Ownership (specif/ effectil/11 date ☐ Other Change (specify typeJ

LICENSE NUMBijR [If applicable) 16AL492-G	WEBSITE (If applicable) www.heartfialdsasslstedllvlngatbowle.com
LEGAL AGENCY E , . - .,i_ C-.1-t- (v b.) , .u...	TRADING NAME (OBA) t«t'4-.0 th o.J.. 0
E--MAIL ADDRESS r- hc.iM,.(,\ :::,€, C, t	PHONE NUMBER 301805--13422 / FAX NUMBER 301•806-8622
BUSINESS ADDRESS (physica locatlon) 7600 Laurel Bowie Road	MAILING ADDRESS (if dilfefent) 7600 Laurel Bowle Road
NUMBER, STREET	NUMBER. STREET
CITY Bowie / STATE MD / ZIP 20715	CITY Bowie / STATc MD / ZIP 20715

Does the owner. corporation. or partnership operate and manage the assisted living program? x Yes No (identify the m nagement structure and its relationship to the business owner)

NUMBER OF RESIDENTS CURRENTLY SERVED	NUMBER0::: BEDS REOOESTED	LEVEL OF CARE REOOESTEO
49	5.2	01 02 1113

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

NAME OF MANAGER Aaron Campbell	PHONE NUMBER (301) 805-8422	CEllNUMBER (443} 421-0282
HOME ADDRESS (number, stmet) 8814 Allen$wOod Ro.id	CITY Randallstown	STA'I'E ZIP MO 21133
NAME OF ALTERNATE MANAGER Daisy Fill'mCr	PHONE NUMBER 301-776-4(122	Cl:LL NUMBER 240-533--6448
HOME ADDRESS (number, street) 10095 Washington Boulevard #218	CITY Laurel	STAT!: ZIP MO 21133
NAME OF OELEGA TING NURSE (ON) Janice Cobb	PHONE NUMBER	CELL NUMBER (443} 676-7350
HOME ADDRESS (num r. s!reet) 8902 Mallar4.Court	CITY Columbia	STATE ZIP MO 21045
ON'S LJCENSI: NUMBER RN55670	EXPIRATION DATE OF DN'S LICENSE 04/2016	

ts your facility plannmg to operate, or currenUy operating, an "Alzheimer's Special Can:, Umt or Program?" DNo
Yes (refer to tle instruction guide for details on submitting your program description)

2. FEES

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

FEE ATTACHED? [XJ Yes

3. OWNERSHIP (Type of business organization of disclosing entity)

SOLE PROPRIETORSHIP PARTNERSHIP CORPORATION

NAME ADDRESS

Five Star - th 11\t) 400 Centre Street, Newton, MA 02458

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

NAME AND TITLE	E-MAIL	PHONE NUMBER	ADDRESS	% OWNED

IF CORPORATION:

DATE OF CHARTER DATE OF INCORPORATION FEIN NUMBER [redacted]

NAME OF PRESIDENT	PHONE NUMBER	CELL NUMBER
ADDRESS (number, street)	CITY	STATE ZIP

4. BACKGROUND

1. Has the applicant, owner, or managerial staff ever had a license, permit or certificate to provide care to third parties that has been denied, suspended. or revoked? [1] No [ ] Yes (explain)

2. Does the applicant currently hold, or has the applicant previously held, any license or certification for the operation of a healthcare facility or similar healthcare program? [ ] No [X] Yes (explain)

3. Does the owner. applicant manager, alternate manager, other staff, or any household member have a criminal conviction or other criminal history? [1] No [ ] Yes (explain)

5. WORKERS' COMPENSATION

Do you have any employees? [1] Yes [ ] No

If You answered YES. provide your **workers'** compensation insurance information:

POLICY NUMBER / INSURANCE COMPANY	EFFECTIVE DATE	EXPIRATION DATE
84"\ 0 Z14		
NM 'Ne-., i,v1	-Z. 1 WI	2 1 Z

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

6. AFFIDAVIT

I solemnly affirm under the penalties of perjury and upon person8l knowledge that the contents of the foregoing application are true. I understand that the falsification of an application for a license may subject me to criminal prosecution, civil money penalties, and/or the revocation of any license issued to me by the DHMH. In addition, knowingly and willfully failing to fully and accurately disclose the requested information may result in denial of a request to become licensed or, where the entity already is licensed, a revocation of that license.

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

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

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

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

SIGNATURE OF APPLICANT	TITLE President & CEO	DATE 9/22/14
SIGNATURE OF APPLICANT	TITIE	DATE
SIGNATURE OF APPLICANT		DATE
SIG ATURE OF APPLICANT	TITLE	DATE

FOR OFFICE USE ONLY

LICENSE NUMBER	FEE $ 130.00	CHECK/MO DATE 9/30/14

STATE OF MARYLAND
Department of Assessments and Taxation

l, .t'AUL 8 . ANOb ltS l>N Or THESTATBDEPARTMENT OF ASSESSMENTS AND TAXATION 01'-THE STATE OF MARYLAND, 00 tHiRl:C13Y C.:ERTll'Y THAT THE DEPARTM6N'I'. SY LI\WS o r THE STAtE,, IS TIIE CUSTODIAN OF THE RECOROS OF THIS STATE RELATING TO THE r'ORFEITURE OR SUSPENSION OF CORPOR.A'fE CHARTERS, OR THE RIOJITS OF CORPORATIONS TO TRANSACT BUSINESS IN THIS STATE AN'D THAT I AM 'rffE PROPER OFFICER TO EXECUTE TH.TS CERTIFJCATE.

I FURTHER CERTlFY THAT C:SQ, INC., QUALIFIED OCTOBER 28, 2002, IS A CORPORATION DULY rncoR.POAATet> ANO EXJSTINGUNDER AND•BY V1R11UE oFTIJE LAWS OF THE STA'I"E OF DELAWARE AND THE CORPORATION HAS F1LED ALL ANNUAL REPORTS 'R QlJI'R.£'0, AAS NO OUTSTANDING LATE FILING PENALT16S ON TIIOSE REPORTS, AND HAr- A RESlDl:!N'I' AGENT. THEREFORE, THE CORPORATION IS AT THli TIMS OF THIS C&RTff'IC;,\TE IN GOOD STANDING WJTHTHIS OEPARTMENT AND DULV AillHORJZB'O TO EXERCISE ALL THE POWERS RECITED IN ITS CHARTHR OR CER11FICATE OF [NCORPORATION, AND TO TRANSACT INTERSTATE, INTRASTATE AND FORBIGN BUSINESS IN MARYLAND.

IN WITNESS WHSREOF, I HAVE HEREUNTO SUBSCRIBED MV SfGNA'TURE AND AFFIXED THE SEAL OF THB STATE DEPARTMENf OF ASSESSMENTS ANO TAXATION OF MARYLAND AT BALTIMORE ON THTS JULY 27, 2012.

Paul B. Anderson
Charter Division

301 West Preston Street, Baltimore, Maryland 21201
Telephone Ballo, Metro (410) 767-1340 I Outside Baito. Metro (888) 246-5941
MRS (Maryland Relay Service) (800) 735 2258 Tr/Voice
Fax (410) 333 7097

crtllnk

R7744472

STATE OF MARYLAND
DEPARTMENT OF HEALTHANQ, MENTAL HYGIENE
Ol?FICE 0.FHEALTH CARE QUALITY

SPRlNG GROVE CENTE:R.
BLAND BRYANT,I3UILDING
55,WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No. **16AL492 G**

Issued to: Fiv Star Quality Care-MD, CLC
T/A Heartfie:tdsAt Bowie
7()00 Laurel Bowie Road
Bowie, MD 20715- L075

Type of Facility or Commul'lity Program:	Numberof Beds:	·· Level of Care:
.Assisted Living	S2	3

TWO YEAR LICENSE

Date Issued: October 25, 20l2 Expiration Date: October 24, 2014

Renewal License - Replaces Lictlnse #16AL492-F

Author i ty to operate in this State is granted to the above entity pursuan t to The I-kaltl1-General Article; Title 19 § **1801,** el. seq., Annotated Code of Maryland, including all applicabk rules and regulatiqns promulgit!!d there undef. This document is not trans ferab le.

h B. Grimm

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Assisted Living Renewal Application - Corporation

Tradt Nontt of Assisted Living /l(HM; (Piuse note any corrections)

License#: 16AL492

HcartFlclds at Bowie
7600 Llurct Bowie Ro11.d
Bowle, MD 20'/.*iS*

Phoiae: 301-805-8422
Em1fil' Addn.n,

Name and phone# or Corponte owner of the bmillcss: (note: tllis will be the entity to wbil:h the liceasc: b i,sucd) Ple1111e note uy eornctio111.

Five Star Quality Caro MD LLC
6177968387

me :owna-opcnlo and - lhemmcdlmDE ladllly?

1f no; idelltify the m■nagcment strueture and Its relationship to the busint:ts owner.

Name of Assisted LMag MKa■ger: Leslie Ray Ceo #:
Number of beds reqaatcd, Sl _ Level or are requested: 3

(Please note any correcliou:}

Hpvc aay **owners,** officers, dinetor agtnu or mHDagr:riaJ c1111ployccs been denied D lk:cnse, l>Ol"fuit, or cerdfieation, or bad a license, permii *or* certificate l'C\'oked toprovide 1:1,re to tltlrd part.its? D Yes *If* No

Hyes, explain:

Doe:, the **applieaot,** as.ilittd liv i: mau cr, stall', or any huutchold member have a nimin11l conv n orotltc:r crimhw history? D Vcs [ti/N -

Ifyes, e:rplain:

Please answer lbo following quc.,tioas rcg:&rdilllg W0rkaen'1 Compensation. This msM be compJcted with your applialtion.

l. Do you h•ve employees? ..Ji.yes - no

!2rtr you answered \'ES to the question 11>0ve pkaic provide the following information:

- Workmen':ii **Compensation** Policy # 0 l '1' /.O 5°'6
- lasurance Company Cb,o.r -l,.t) tos!AP':-1h,-
- Effective date: of policy 11-
- hpintio11 date or policy z.-i/_1.,_/_t–

Tw.c<2) Year Application Fee Required:

ief TQTAL.DUE! S 892 Deputmcnt of Health and Mental Hyg c(D>HMH) rechomesin:ipeaed by OHCQ

• MDoA, DKR and lot.al health departments may collect addltlon111 fee!i.

Based upon the option e please enclose ll noa-refuacblble fee (bu in l'- check nr money order only) made pay11blc to **the "DHMH", Marylarad State *of* Department** or Health and Mentlll Hygiena. (NO PERSONAL CH£CKS)

Printed 08/22/12

DurinKthe2002Gcnt!ral Se!sion SenateBill746 entiticd *Ak/leimu'sSp«ialCareUnitorProgram* wasenacted into law. Assisted Living Programs offering scn>ic:cs to individual!' with Alzheimer's or a related disorder may need to develop ll **program** description asoutlioin thelaw. Thedefinitioncontained in SB 746 is11bown below. If youranswertothe question is "yes", please follow the Instructions for submission of your program description/

Does your fncility opcrnte nn .. Attheimcr•s Special Care Unitol' Pl'(lgrmn""! yes IJZf no 0

If yes, please submii to t!,h,q_ffir.:c D d ription 0f your Atdlcimcr'5 Special Care Unit-or P.r,r;;r ..... , ;:·l-; c-h !!lst include:

A mtement of philosophy or miaion;
Staff tt"Qinh1g 11Dd staff job titl ;
Admislio1' procedura meh1ding scree.Ing crite ; 0 (\ \o vi) / \'--.. u-r,A 1 1---
Assessmont and CBI'$ plannlng protocol; -{" 1/ \ \,-t1
SW'Dng patterns
A description oftlNI physieal environment **and an)'** uniquedeslen features appropriate to support tbe ranctionint of eognitively Impaired illdividuals;
A dcsuiptiou of'ac:mities includiui frequeni;iy aad type..;
Charp$ **W ick,nlill for''''** provicled by tfMl Alzbeimar'll Special C111re or Program;
.... -1. .....l>J,tb.tlr.gc..procedu.res
Any services, **tnining,** or other proeeourcs th.at src over and •bove those that are providcid In the etisting ASSided living program:.and

{YOUR RENEW AL LICENSE CANNOT BE PROCESSED WITHOUT THESE DOCUMENTS)

Fire **Inspection** Report:

Scind In a copy of your approved nrc lns on report. Please Contact:
Prince George', County Fire/EMS Department .Fire Prevention Office Fll'C Services BuUdlnit, 6320 Webster Street, Landover, **Maryland** '.207&4, 301-583-1 0.

OtbcrN :

Food Service **Permit-** Please scud **ia a** copy of your facility's food service permit from yoar county.
Corpora&n Good Standing Document - Please submit a coPY from the State of Maryland. Assessments & Taxation office for your **corporation** status. Print out ur status onllnc; - http:// datcc:rt3, iusa,9r:2/1JCC-hurtct/CharterScarch r.a!ipx can fr at I-888-146-5941.

Signature of two corporate officers required:

Name Paul V. Hoagland Title Treasurer and CFO 10/9/12 Date

Name Bruce J. Mackey, Jr Title President and CEO 10/9/12 Date

I, o.....J Ci.. <:- r,, do sol mnJy declare and affirm under penalties of perjury that the contents oft e foregoing application are true to the best of my knowledge, information, and belief. 1 understand that the falsification of an application for a license shall subject me to **criminal** prosecution, civil **money penalties,** and/or the revocation of any license issued to me by the Dcpntmcnt of IleaJth and Mental Hygiene. ,,

(For office use only)

Fee: $92.00 Cb k/MO#: [redacted] Date of Check: 10/9/2012

OWNERSHIP FORM

The completion of this form ls necessary for initial licensure and license renewal. PIHSe attach the tOmP,leted form to your license appllcatio11. All spaces in this form must be completed. If a particular section docs not apply, insert the phrase "Not Applicable" or "NIA".

Type of **Basin6-.** Orga1:1ization nfDisdoliing Entity (check nne}:

☐ SOL PROPRIETORSHIP
Name of Owner _____ Email Address: _____

Home Street Address of Owner _____

Ctty. Stste& ZipCo d _____

D PARTNERSHIP
Nam _____ £mail Address: _____

Home Addres_s _____

City, State& Zip Code _____

Name(s), Title(s), Address(es) and Telephone Number(s) of Partners and Percentuge Owned if2% or More

Name	Title	Einail AddnlS8	Telephone Number	Bomc Address	% Owned

[J **CORPORATION**
Name of Corporation _____
Address of Corporation _____
City, State& ZipCode _____

Corpon1tion **President** Name, Addl'CJS and Telephone Number: _____

HPLEASK NOTE: You mut 111b111it • copy of yo11rl(IOd9tanduig vul(,catioo **f'ro111 the State of Maryland, Ane1m•cnti&'raxatloa** office.

Name(s). Tltle(s)Addre."lS(es) and Telephone Numbet(s)ofOffi r(s), Director(:i), Stockholdcr(s)& percentageowned If 2%ormore

Name	Title	Email Address	Telepbobc Nwnber	Boane Address	% Owned

Date of Charter _____ Oate of Incorporation _____

FEIN# _____

OWNERSHIP FORM

OTHER (specify) l_;M;teJ l_;a_b; /,¾ L{

Should aforementioned corporc1tion or panncrsbip be wholly or partly owned by another organization, the following shall be completed with respect to the organiiation owning all or part of the disclosing entity: List percentage owned if2% or more,

Address" *ifoo Ce..:¼* J.Je.!+!kn-,jMJt LdG.s:'$

Name	Title	Ema.1 Address	Telephone Number	Homo Address	% Owned
'?\ e					
	\\A.				

Type Of Control (,l:,hcck one)

Voluntary
No Profit

0 Church
D Other (specify)

7

Government

D State
D County
0 City
0 City/County

Leruring Ai:rnggemcnt

If thedisclosing entity operates the business under a lease, thefollowing section shaJl be completed and a copy of the lease attached.

Lcssco Name(s) & AddrellS(es)
{allO known us - Tenant)

'\Je s\tM ¾ Wt f.:),w...
4oD W<e 0.- IM.f! tvt i

Expiration Date of Lease _ {zJ.3< J l ,zJ)2D

Leasor Name(s) & Addrcss(es)
(also known as - Laodlord)

S}J" U\s \\ es \'tv..s+
255 L; BiDri, 6t N yt\(-\ 5'8

"I, a.-\ 0- la.-J a....,J '.t,ru..et; f. .V. do solemnly declare and aftinn under penalties of perjury that the contents oftheregoing appli<:ationare'lructothebestofmy knowledge,, information, and belief. I undcn;tand that the falsification of an application for a lfccnscshall subject me tocriminal pro cution, ci il money penalties, and/or the revocation of any li issued to e by the Department of Health and Mental Hy$i e. ".;·-

***(I'te** " If r A.ssl.Jtttl Ll,ing Progrum Is ROl,q:"1 **be In** INn &,,,. one applicant's* IIGIISt'j ***tad** 11PPllc»m1'1t :signahlre b **rt:qMired** oli tllh/arm)*

Signature of Applicant(s):

Name Paul K. Hoagland — Treasurer (Title) — 10/9/12 (Date)

Name Bruce J. MAckey, Jr — esident and CEO (Title) — 10/9/12 (Date)

STATE OF MARYLAND
Department of Assessments and Taxation

I, PAUL B. ANDERSON OF THE STATE DEPARTMENT OF ASSESSMENTS AND TAXATION OF THE STATE OF MARYLAND, DO HEREBY CERTIFY THAT THE DEPARTMENT, BY LAWS OF THE STATE, IS THE CUSTODIAN OF THE RECORDS OF THIS STATE RELATING TO THE FORFEITURE OR SUSPENSION OF CORPORATE CHARTERS, OR THE RIGHTS OF CORPORATIONS TO TRANSACT BUSCNESS IN THIS STATE AND THAT I AM THE PROPER OFFICER TO EXECUTE THIS CERTIFICATE.

I FURTHER CERTIFY THAT FSQ, INC., QUALIFIED OCTOBER 28, 2002, rs A CORPORATION DULY INCORPORATED AND EXISTCNG UNDER AND BY VIRTUE OF THE LAWS OF THE STATE OF DELAWARE AND THE CORP0RNf.ION I-IAS fl l :ED ALL A:NNU AL REPORTS REQUIRED, Hi\S NO OUTSTANDING LATE FILING PENALTIES ON THOSE REPORTS, AND HAS A RESIDENT AGENT. THEREFORE, THE CORPORATION IS AT THE TIME OF THIS CERTIFICATE IN GOOD STANDING WITH THIS DEPARTMENT AND DULY AUTHORIZED TO EXERCISE ALL THE POWERS RECITED fN ITS CHARTER OR CERTIFICATE OF INCORPORATION, AND TO TRANSACT INTER.ST ATE, INTRASTATE AND FOREIGN BUSfNESS IN MARYLAND.

IN WITNESS WHEREOF, I HAVE HEREUNTO SUBSCRIBED MY SIGNATURE AND AFFIXED THE SEAL OF THE STATE DEPARTMENT OF ASSESSMENTS AND TAXATION OF MARYLAND AT BALTIMORE ON nus JULY 27, 2012.

9

Paul B. Anderson
Charter Division

301 West Preston Street; Baltimore, Mmyland 21201
Telephone Ba/to. Metro (410) 767-1340 I Outside Ba/to. Metro (888) 246-5941
lvJRS (Maryland Relay Service) (800) 735-2258 TT/Voice
Fax (410) 333-7097

crblnk

R7744472

m

Entity Nume: Fl VE STAR QUALITY CARE-MD, LLC
De tlD #: 206979470

General lnfonnntion **Amendments** Personal l'roperty Certincnk of St1uus

Principal Oflicc **{Current):**	2711 CENTERVILLE RD. STE. 400 WILMINGTON, DE 19805
Resident Agent (Current):	CSC-LA WYERS INCORPORATING SERVICE COMPA 7 ST. PAUL STREET, SUITE 1660 BALTIMORE, MD 21202
Status:	
Good Stand ing:	Yes **WIIHI**11111·,it1111·:,11wh,:11ah11.,i11,.,i. nuf i11 uut,f 1:111dini:...forfri11:11"!
Business Code:	Other
Dal of ljormntlon or Rr.gistnttion:	09;04noo2
Stute ur Formation:	DE
Stock/N1msl11ck;	*NIA*
Close/Not Close:	Unknown

J

!Link Definition

General Information	General information about this entity
Amendmcnls	Original and subsequent documenls filed
Personal Property	Personal Property Return Filing Information and Property Assessments
Certificate of Status	Get a Certificate of Good Standing for this entity

Maryland Assisted Living Program

Uniform Disclosure Statement

What is the Purpose of the Disclosure Statement?

The purpose of the Disclosure Statement is to empower consumers by describing an assisted living program's policies and services in a uniform manner. This format gives prospective residents and their families consistent categories of information from which they can compare programs and services.[1]

IIis important to note that the Disclosure Statement is not intended to take the place of visiting the program , talking with ; ,resident,s.or meeting one-on-one with staff. Nor is the statement a.bir,ding.cpn.tr.act.ocsubstitute for the Resident Agreement. Rather, it serves as additional information for making aninformed decision about the services provided in eachprogram.

If you have any questions about any issue raised in the Disclosure Statement or in the Resident Agreement provided by an assisted living program, please seek clarification from that program's manager or administrator.

What is Assisted Living?

Assisted living is a way to provide care to people who are having difficulty living independenUy. Assisted living providers furnish a place tolive,meals, andassistance with dailyactivities suchasdressing,bathing, eating, andmanaging medication.sAssisted living programs also tend to have a less institutional look than nursing homes.However, these facilities are not as highly regulated by the State as nursing homes. There are a wide variety of assisted living programs in Maryland. They range from large,corporate-managedfacilities wherehundreds of people liveintheir ownapartments tosmall, private homes.

Assisted living programs may differ in many ways including, but not limited to: size, staff qualifications, services offered, location, fees,sponsorship, whether theyarefreestanding orpartofacontinuumofcare, participation intheMedicaid Waiver, ability to age in place, and visitinghours. Therefore, consumers should try to have a general idea of what type of setting, services, and pricerangetheymaywantbeforecontactinganassistedlivingprogram,aswellashavingquestionsprepared toaskthe program manager or administrato.rConsumers may find the Maryland Department of Aging's publication entitled,'Assisted Living in Maryland: What You Need to Know,"helpful when they are contemplating assistedliving. The publication may be downloaded from the Department of Aging's Web site. (http://www.mdoastate.md.us/documents/AGuide_002pd

In addition, the Office of Health Care Quality (OHCQ) encourages consumers to verify the licensure status of any assisted living program that they are considering. A list of licensed assisted living programs is available online. (http://www.dhmh.maryland.gov/ohcq/about_ohcq/licensee_directory.htm)

Where can I find the Assisted Living Licensure Standards?

The Assisted Living Licensure Standards are found in the Code of Maryland Regulations (COMAR) 10.07.14,available at public libraries, online at http://www.dsd.state.md.us/comar/ororderedfor a small fee from the OHCQ. A copy of the most recent.,,,.. ,. survey report of an assisted living program may be obtained from the program's manager or administrator.

[1] Assisted Livingproviders are not reqwrfil! to provideall of the services listed in the DisclosureStatement- regulatory requirements may be found in COMAR 1007.14.

1) Assisted Living Program Contact Information:

Facility Name HeartFields at Bowie	
Ude St No.1?Ai:'!i r[," "	No. of Lic ns(;)d Bfl(Is52. " " •. ,.,) ,.,Level of Care at which Facility is •·. ·I Licensed 3
Address (Street. City, State, Zip)7600 Laurel Bowie Road Bowie, MD 20715	
Phone Number 301-805-8422	Fax Number30-805-8622
E-Mail Address (optional)	Operator/Management Company 5 Star Senior Care
Manager Jennifer Harris	Contact Information 301-805-8422
..OelegatiQg-l}lurse.Mar:y.Morgari, *RN*	Contact Inform1ati0n 30.W0li 8.l.22. . . ,
Alternate Manager Daisy Farmer	Contact Information 301-805-8422
Completed By Jennifer Harris	Title Executive Director Date Completed8/5/2010

2) What sources of payment are accepted?

Assisted living programs differ in what types of sources they may accept for paymen,te.g. private insurance, Medicaid, private pay, SSI/SSDI, etc. What sources of payment are accepted at this program?

private pay

3) What are levels of care?

The levels of care correspond with how much assistance residents need. The level of care designation, therefore, reflects the complexity of the services required to meet the needs of a resident. The State of Maryland recognizes three levels of care, and they are as follows: Level 1 is low level of care required, Level 2 is moderate level of care require, dand Level 3 is high level of care required.

A resident's level of care is determined by the Resident Assessment Tool, which collects essential information about a resident's physical, functional, and psychosocial strengths and deficits. There are two components to the assessment tool - a Health Care Practitioners Physical Assessment, to be completed or verified by a health care practitioner, and the Assisted Living Manager's Assessment, tobecompletedby theAssisted LivingManager or designee. Aresident's score ontheassessment tool determines his/her level of care (Level 1 = a total score of 0-20: Level 2 = a total score of 21-40:and Level 3 = a total score of 41 or higher).

Some assisted living programs may have elected todevelop.morethan three levels ofcare. If an assisted livingprogramhas more than three levels of care, please describe the levels of ewe and how they correlate to the three levels of care recognized by the State. In addition, include program charges for each level. of care.

Explanation: (You may attach materials as neceuo,y) Level ◀ i• c>re that a re,ldent may have the need for prin te duty, it maybe that the re,ident ma y need **Hospice Caret maybe an elo pement risk with bracelet, or may need care abo"Ye the score or 56.**

4) What is a Resident Agreement?

The resident agreement is a legal contract, obligating a consumer to provide payment in return for services to be provided by the assisted living program. An assisted living program will provide a consumer with a Resident Agreement to review and sign prior to move-in. Prospective residents should feel free to request a copy of a sample resident agreement at any time.

The resident agreement is required by regulation to include, at a minimum, the information provided in COMAR 10.07.14.24(D) and 10.07.14.25(A), such as: the level of care the program is licensed to provide, a list of services provided by the program, an explanation of the program's complaint or grievance procedure; admission and discharge policies and procedures; obligations of the program and the resident or the resident's representative with regards to financial matters-handling resident finances, purchase or rental of essential or desired equipment; arranging or contracting for services not covered by the resident agreemen;tratestructure and payment provisions;identification of persons responsible for paymen;tnoticeprovisions for rate increases; billing, payment, and creditpolices; and terms governing the refund of any prepaid fees or charges in the event of a resident's discharge or termination of the resident agreement.

5) What Services are Provided?

Consumers should expect assisted living programs to provide clear information regarding services and fees. Some programs may charge fees for services based on the resident's assessed level of care, while others may provide an "ala carte" menu of services. Consumers should understand what is included in the base monthly rate, what services require an additional charge, circumstances under which fees may increase, and the refund policy. Below is a chart to help consumers better compare assisted living programs. This chart is not all-inclusive and providers may offer more or fewer services than listed below.

Offered		Service	Included in Base Rate for Level of Care (yes/no)	May be Purchased Separately. If so, please indicate cost
Yes	No			
Nursing and Clinical Care:				
	LJ	24-Hour Awake Staff, Including Awake Overnight Staff	yes	
		Nursing Review Every 45 Days (Required by COMAR)	yes	
	LJ	On-site Licensed Nursing / Hours/Week)	yes- 24/7	
		Physician Services	yes	cost per doctor
		Bladder Incontinence Care	yes	LOC
	LJ	Bowel Incontinence Care	yes	LOC
u		Catheter Care	n/a	n/a
		Consultant pharmacist medication review (required in some cases)	yes	
	☐	Diabetes Care	no	LOC
		End of Life Care	no	hospice services
	LJ ☐	Home Health	no	outside provider charges- svs can be done in house
	☐	Hospice Care	no	outside provider charges- svs can be done in house, outside provider charges $46.00
		Incontinence Products	no	product charges depends on product
	LJ	Infection Control Materials (e.g., gloves, masks, etc.)	no	
		Nutritional Supplements	no	purchased by family

0	☐	Service Planand Frequency (Required by COMAR at least every 6 months)	yes- at move in, PRN and at least every 6 months	
0	☐	Temporary use of wheelchair/walker	yes- if available	

Offered		Service	Included in Base Rate for Level of Care (yes/no)	May be Purchased Separately. Ifso,please indicate cost.
Yes	No			
Personal Care:				
	☐ ☐	Arrange/Coordinate Medical Appointments	yes- assistance provided i-f requested	
183	☐	Assistance.with bathing	no	LOC
f2.'.l		Assistance with dressing	no	LOC
	u	Assistance with handling money	N/A	
		Assistance with incontinence	no	LOC
☐	183	Assistance with preparing meals	all meals included in Base rent	
183	u ☐	Assistance with shopping for food or personal items	yes- with activity program	
183		Assistance with toileting	no	LOC
u	Qg ☐	Companion Services	no	outside provider charges-svs can be done in house
f2.'.l		Housekeeping	yes	
l8l	u	Mobility/*T*ransfer Assistance	no	
u	l8l	Personal Care Items	no	
Environment:				
	u	Activities program(days per week), specify programs or attach calendar.	yes- see attached- provided 7 days a week	outside activites are also offered at your cost if requested
183	u ☐	Alcohol Consumption	yes- if part of activity program	with MD order
	u	Barber/Beauty Shop	no	prices posted in salon
	u	Cable TV	no	call cable provider
u	183	Fire Sprinklers(_ in all areas or in some areas), specify:	yes - in all areas	
		Internet Access	(,10	call internet provider
l8l		Linens/Towels	yes	
LJ	183	Chair Glide System		
☐	Qg	Dry Cleaning Services		
LJ	☐	Elevators	no	
£83		Emergency Call System	yes	
ll$J		Emergency Generator	yes	

181	☐	Fire Alarm System	yes	
☐	[81	Automatic Electronic Defibrillators (AEDs)	no	
181	☐	Handrails	yes	
181	LJ	Personal Laundry	yes	
181	☐	Personal Phone	yes- local included	long dista ce charged back to resident
181	LJ	Pets Allowed, specify:	no	refer to pet policy
f8I	LJ	Ramps	yes	
181	LJ	Security Servics. specify:	yes- locks, alarm system	
	LJ	Smoking	yes- outside only	
	LJ	Secured Areas	no	LOC in ALZ. area
181	☐	Sprinkler system	yes	
f8I	☐	Transportation, specify	yes- some with activity program	pay request private transportation thru heartlands ($55 pr trip) or with an outside provider
181	☐	Visitation, specify hours and include the facility's policies and procedures	yes- open 24/ 7 for visitors	lobby phone doors locked after 7pm
Offered		Service	Included in Base Rate for Level of Care (yes/no)	May be Purchased Separately. If so, please indicate cost.
Yes	No			
Environment: (Continued)				
	LJ	Volunteer Services, specify and include the facility's policies and procedures	yes-thru activity department	continue
	☐	Wander Guard or similar system. specify:	no- wanderguard $100 per month	75.00
Dietary:				
	LJ	Meals (per day & snacks) {COMAR requires a minimum of 3 meals per day & additional snacks)	yes 3 meals per day + snacks	guest meals charged at posted rate
181	LJ	Special Diets, specify:	yes- No added salt, no concentrated sweets, mechanical soft. puree	
f8I	☐	Family or Congregate Meals	no	guest meals charged at posted rate
Pharmaceuticals/Medications:				
L J	{X}	Durable Medical Equipment, specify:		physical therapy
181	☐	Medication Administration	LOC	$11 or $15 per day
181	0	Medicatidn Injections	LOC	$15 per day
	☐	Pharmaceuticals	no	cost per item thru pharmacy
	☐	Self Administration of Medications Permitted	yes	
181	☐	Use of Outside Pharmacy Permitted	yes mail order	medication management charges apply

I2J	☐	Use of Mail Order Pharmacy Permitted	no	medication management charges apply
Specialized Care or Services:				
I2J	☐	Behavior Management: Verbal Aggression	yes	may need - depending on ss,v3rit1outsid ; • provider charges- svs can be done in house
☐	☐	Behavior Management: Physical Aggression	yes	may need - depending on severity outside providercharges- svs can be done in house
!XI	l J	Dementia Care	yes	$32.00 per day LOC
	I2J	Intravenous Therapy		
I2J	☐	Mental l:lealIhS.UimP.ct$._a o<lS.el.\Ic!3S, .specify;	no	.....P.utside,prnvjder _ ... charges- svs can be done in house
!XI	!XI	Ostomy Care		
I2J		OxyQen Administration	yes/no	may be LOC
	☐ u	Special Care Units, if there are additional charges for this type of care, please specify cost difference as well as how those services differ from the services provided in the rest of the program.	no	Alheimer's LOC
		Services for persons who are blind	no/ yes	LOC
LJ		Staff who can sign for the deaf	N/A	
	[81	Bilingual Services	N/A	
	[81	Tube Feeding	**N/A**	
	☐	Wound Care	no	$7.00/day after seven days

Are the resident, resident's representativ e, or family members involved in the service planning process? t8l Yes O No

Explanation: (option a l) Initial asse,sment, as needs change, **PRN** and every 6 months a family meeting is offered

Is the service plan reviewed with the resident. resident's representative, or family members? t8] Yes D No

Explanatlon:(optionaJ) **Ini ti al assessment, as needs change, PRN and •••rt 6 months a fam ily meeting is offered**

Who assists with or administers medications? {Check all which apply)
12J Delegating Nurse/Registered Nurse **[81** Licensed Practical Nurse D Medication Technician O Other (specfiy):

6) What are the¢· t eri for discharge or transfer?

The followingis a list of situations that may necessitate the termination of the resident agreement and the-transferor discharge of a resident from an assisted livingprogram. Consumers areencouraged toinquire about an assisted livingprogram's policies andprocedures in theevent that a resident mustrelocate. Thislist is notall-inclusive andcriteria willdiffer depending upon the assistedliving program's ability to provide certain types of care. All transfers and discharges must comply with Maryland regulatory requirement,sincluding notice requiremen,tsand terms of the Resident Agreement.*·

Criteria/Factor which may:	Cause (temporary) transfer	Cause (permanent) discharge	Require the use of external resources
Medical condition requiring care exceeding that of which the facility determines it can safely provide	l8l	181	l8l
Unacceptable physical, verbal, or sexual behavior	l8l	181	[8J
Medication stabilization	[8J	[8J	rzl
Danger to self or others		[8J	
Inability to toilet	☐	☐	☐
Non-ambulatory		rzl	LJ
Inability to eat/tube feeding	☐		☐
Must be hand fed	LJ	LJ	LJ
Inability to walk/bedfast	▪	rgJ	-
Others:	18]	l8l	rgJ
Mental health issues, specify:	18]	l8l	☐
Mobility changes	☐	☐	18]
Needs skilled nursing care			LJ
Requires sitters	rgJ	[8J	lZl
Medication injections	☐	☐	LJ
Behavior management for verbal or physical aggression	18]		t8]
Bladder incontinence care	☐	u	LJ
Bowel incontinence care	LJ	☐	☐
Intravenous (IV) therapy	l8l	l8l	☐
Level of care change	181		
Moderate or advanced dementia, specify:	☐	LJ	☐
Memtal Health Issues (from above- conditions requiring aggressive treatment,	181	18]	☐
Others- from above- Wound care	181		18]
	LJ	LJ	LJ
	☐	u	LJ
	LJ	LJ	LJ

'Under Maryland Regulations an assisted living program *may* not provide services to an individual who at the 1ime of initial admission, as established by the inijial assessment. requires: (1) More than intennittent nursing care; (2) Treatment of stage three or stage four skin ulcers; (3) Ventilator services; (4) Skilled monitoring, testing, and aggressive adjustment of medications and treatments where there is the presence of, or risk for, a fluctuating acute condition: (5) Monitoring of a chronic medical condition that is not controllable through readily available medications and treatments; or (6) Treatrnent for a disease or condition which requires more than contact isolation. Exceptions to the conditions listed above are provided for individuals who are under the care of a licensed general hospice program.

Who makes the resident discharge or transfer decision?

181 Assisted Living Manager
[8J Delegating Nurse
D Registered Nurse
181 Other (specify) management team

Do families have input into the discharge or transfer decision? **l8l** Yes **D** No

Is there an avenue to appeal the discharge or transfer decision? **l8l** Yes D No

Explanation:(optional) may call corporate 5 Star Quality Care- Gold Star line

, . .,,: • 002: tl1& assisted living program assist families in making discl:::;,gs or t.-w": . µ:Jns? !ZI Yes D No

Explanation:(optional) will as,i,t lamilie, with transfer to another **AL,** IL, ALZ, Skilled, etc

7) What are the requirements for staff training?

, ...,,,."""....- ,'",· ,COMAR requires that assisted living programs provide iriitialtmd annual training for·the·alternate manager and staff in: (a) fire··"·, ,,;:.,,,,,,in""'' and life safety, including the use of fire extinguishers; (b) infection control, including standard precautions, contact precautions, and hand hygiene; (c) basic *food* safety; {d) emergency disaster plans; (e) basic first aid by a certified first aid instructor; and (0 cognitive impairment and mental illness training. Staff must have training or experience in: (a) the health and psychosocial needs of the population being served; (b) the resident assessment process; (c) the use of service plans; and (d) resident rights. A sufficient number of staff must also have initial and ongoing training in CPR training from a certified instructor. Consumers are encouraged to talk to the assisted living program manager about sources of staff training and their qualifications.

COMAR requires that assisted living program managers have sufficient skills, training, and experience to serve the residents in a manner that is consistent with the philosophy of assisted living. Managers must have verifiable knowledge in: (a) the health and psychosocial needs of the population being served; (b) the resident assessment process; (c) use of service plans; (d) cuing, coaching, and monitoring residents who self-administer medications with or without assistance; (e) providing assistance with ambulation, personal hygiene, dressing, toileting, and feeding; and (D resident rights. Managers must receive initial and annual training in: (a) fire and life safety; (b) infection control, including standard precautions; (c) emergency disaster plans; and (d) basic food safety. Managers are required to have initial certification and recertification in: (a) basic first aid by a certified first aid instructor; and (b) basic CPR by a certified CPR instructor.

COMAR requires that assisted living program managers of programs licensed for five beds or more have completed an 80-hour manager's training course. Some managers are exempt from this requirement.

Some assisted living programs may elect to require training for staff, managers, and alternate managers beyond these requirements.
Additional training provided: _____

8) What is the assisted living program's staffing pattern?

COMAR requires assisted living programs *to* develop a staffing plan that includes on-site staff sufficient in number and qualifications to meet the 24-hour scheduled and unscheduled needs of the residents. The delegating nurse, based on the needs of a resident, may issue a nursing order for on-site nursing.

SHIFTS (Enter the hours of each of your facility's shifts)	NUMBER OF STAFF PER SHIFT PER DAY							
	RN	LPN	CNA	Medication Tech.	Activity Workers	Non• Licensed Assistiva Personnel	Other Workers	Awake . Overnight
7am-3pm		1	4 may be C.N.A. or Non-			4 may be CN.Aor NON C.N.A	7	

			C.NA					
3pm-11pm & 4pm-8pm		1	4 May be C.NA or Non-CN.A. 2 may be C.N.A. or non-C.N.A.			4 May be C.N.A. or Non-C.N.A 2 may be Non-C.N.A.	1	all
11am-7pm		1					1	
11pm-7am		1	2 May be C.N.A. or Non-C.N.A.			2 May be C.N.A. or Non- C.N.A.		3 - all awake staff
8am/9am-5pm					1		Mgmt/desk staff-8	

If staff do not work on a per-day basis, indicate the onsite hours per month.

RN	LPN	Physician	Social Worker	Phannacist
delegating RN	2232	Monthly		QUARTERLY

Explanation: Delegating RN is a contractual employee, Pharmacist reviews resident charts quarterly

9) How do I file a complaint?

Under Maryland regulations, assisted living programs are required to have an internal complaint or grievance procedure. An explanation of the assisted living program's internal complaint or grievance procedure must be included in the resident agreement. Consumers should review this information and make sure that they understand how the internal complaint or grievance procedure operates. Consumers should direct any questions about the internal procedure to the assisted living program's manager or administrator.

Consumers may also report concerns or file a complaint regarding an assisted living program to the Office of Health Care Quality. Complaints may be registered over the phone or through the OHCQ Web site. Complaints may be anonymous. For more information regarding filing a complaint, please visit the Office of Health Care Quality's Web site at http://www.dhmh.state.md.us/ohcq/faq_help/file_a_complaint.htm or call (410) 402-8217 or 1-877-402-8218.

Maryland Departme11t of)·J.e.alth;i,nd Mental Hygiene-Office of Health Care Quality
Spring Grove Hospital-Center-Bland Bryant Building
SS Wade Avenue
Catonsville, Maryland 21228
Phone: (410) 402-8000 Toll Free: 1-877-402-8218
www.dhmh.state.rnd.us/ohcq

(Tags: Trial attorney, nursing home lawyer, nursing home attorney, overmedication, medication error, pressure sores, bed sores, decubitus ulcer attorney, sepsis, wrongful death, wounds, falls, attorney handling medication errors, nursing home abuse attorney, assisted living attorney, assisted living accidents, pressure sore attorney, bed sore attorney, dehydration, malnutrition, Maryland abuse attorney, Prince Georges nursing home attorney, Prince Georges personal injury attorney, nursing home injury, skilled rehab injury, skilled rehab attorney, drugs, pharmaceutical drugs, antipsychotic drugs, negligence attorney, nursing home abuse attorney, adult protective service lawyer, overdose, legal liability for overdose, nursing home abuse lawyer, nursing home chains, statistics on nursing home abuse, Maryland abuse attorney, silver spring nursing home attorney, five star senior living, wrongful death, pressure sores, at Heartfields of Bowie, negligence involving Heartsfield of Bowie)

RECEIVED

STATE OF MARYLAND
DEPARTMEITT OF HEALTH AND MENTAL HYGIENE (DHMH)
OFFICE OF HEALTH CARE QU.!.UTY (OHCQ)

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Office of
Health Care Quality

ASSISTED LIVING

APPLICATION FOR LICENSURE

1. GENERAL INFORMATION

CHECK TYPE OF APPLICATION

D Initial | Iii Renewal | D Change of Ownership (specify effective date) | D Other Change (specify type)

LICENSE NUMBER (if applicable) **16AL492-H**	WEBSITE(if applicable) **www.heartfieldsassistedlivingatbowie.com**
LEGAL AGENCY NAME Five Star Quality Care-MD, LLC	TRADING NAME (OBA) HeartFields at Bowie
E-MAIL ADDRESS adcampbell@5ssl.com	PHONE NUMBER **301-805-8422** FAX NUMBER **301-805-8622**
BUSrNESS ADDRESS {physical location) 400 Centre Street	MAILING ADDRESS (if drfferent) 7600 Laurel Bowie Road
NUMBER, STREET	NUMBERSTREET
CITY Newton STATE **MA** ZIP **02458**	CITY **Bowie** STATE **MD** **ZIP 20715**

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

NUMBER OF RESIDENTS CURRENTLY SERVED	NUMBER Of BEDS REQUESTED	LEVEL OF CARE REQUESTED
52	52	☐ 1 ☐ 2 **lil3**

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

NAME OF MANAGER Aaron Campbell	PHONE NUMBER (301) 805-8422	CELL NUMB.ER **(443) 421-0282**
HOME ADDRESS (number, slreel) 1019 Meherrin Court	CITY Glen Burnie	STATE **MD** ZIP 21060
NAME OF ALTERNATEMANAGER Patricia Coley	PHONE NUMBER	CELL NUMBER (240)498-5339
HOME ADDRESS (number, street) 4001 Buck Creek Road	CITY Temple Hills	STATE MD ZIP 20748
NAME OF DELEGATINGNURSE (ON) Patricia C(?ley	PHONE NUMBER	CELL NUMBER (240) 498-5339
HOME ADDRESS (numbe, rstreet) 4001 Buck Creek Road	CITY Temple Hills	STATE **MD** ZIP 20748
DN'S LICENSE NUMBER	EXPIRATION DATEOFDN'SLICENSE	

Is our facility planning to operate, or currenfiy operating, an 'Alzheimer's Special Care Untt or Program?" U No
li Yes (refer to the instruction guide for details on submitting your program description)

det in th for th n rf dabl; li s fee a d ptedmethod 0f p ym nt, refer to th instruction guide.

FEE ATTACHED? Iii Yes

3. OWNERSHIP (Type of business organization of disclosing entity)

☐ SOLE PROPRIETORSHIP | ☐ PARTNERSHIP | ☒ CORPORATION

NAME	ADDRESS
FiveStar Qual ity Care	400 Centre Street, Newton, MA 02458

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

NAME AND TITLE	E-MAIL	PHONE NUMBER	ADDRESS	% OWNED

IF CORPORATION:
DATE OF CHARIER | DATE *OF* INCORPORATION | FEIN NUMBER

NAME OF PRESIDENT	PHONE NUMBER	CELL NUMBER
ADDRESS (number, street)	CI1Y	STATE ZIP

1. Has the applicant, owner, or managerial staff ever had a license, permit, or certificate to provide care to third parties that has been denied, suspended, or revoked? [j] No D Yes (explain)

2. Does the applicant currently hold, or has the applicant previously held, any license or certification for the operation of a health care facility or similar health care program? D No Iii Yes (explain)

3. Does the owner, applicant, manager, alternate manager, other staff, or any household member have a criminal conviction or other criminal history? i] No D Yes (explain)

5. WORKERS' COMPENSATION

Do you have any employees? ■ Yes ☐ No

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

POLICY NUMBER	BINDER NUMBER	
L□S4055032	PS4055033	
INSURANCE COMPANY	EFFECTIVE DATE	EXPIRATION DATE
Safety National Casualty Corporation	June 15, 2016	June 1, 2017

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

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

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

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

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

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

SIGNATURE OF APPLICANT	TITLE	DATE
	President & CEO	10.27.16
SIGNATURE OF APPLICANT	TITLE	DATE
SIGNATURE OF APPLICANT	TITLE	DATE
SIGNATURE OF APPLICANT	TITLE	DATE

FOR OFFICE USE ONLY

LICENSE NUMBER	FEE	CHECK/MO #	CHECK/MO DATE
	$ 330.00	212364	10-18-16