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

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

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

Maple Ridge Group Home
15908 Maple Ridge Ct
Rockville, MD 20853

Characteristics:

- Assisted Living Facility with 16 beds
- Legal Business Name – Potomac Manor LLC
- Administrator – Ruth Fishman
- www.cedarcreekassoc.com

Researching Nursing Homes

A note by attorney Jeffrey J. Downey:

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

The Maryland Department of Health inspects nursing homes and assisted living facilities including Maple Ridge Group Home in Rockville, MD. Periodically they do inspections as complaint surveys which should be public record.

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

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

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

2) Fax : 410-402-8179

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

Having already researched Maple Ridge Group Home in Rockville, 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.

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
	AL001812	A. BUILDING: _____ B. WING _____	06/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE RIDGE GROUP HOME	15908 MAPLE RIDGE CT ROCKVILLE, MD 20853

(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 6/12/19 an inspection of care survey was conducted by representatives of the Office of Health Care Quality 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 resident, observations, and a tour of the facility. The facility census at the time of the survey was 13 Residents. Based on survey findings, the facility was determined to be in compliance with COMAR 10.07.14, Assisted Living Program regulations.	E 000		

OHCQ

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

Office of Health Care Quality

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EOOO	Initial Comments On June 20, 2017 an inspection of care survey (IOC) was conducted by a representative of the Office of Health Care Quality to determine if the immediate health and safety needs of the residents were being met and to determine compliance with **COMAR** 10.07.14, Regulations for Assisted Living Programs. Additionally, an inspection was conducted for a requested bed increase from 14 to 16 residents. Survey activities included a review of selected administrative, staff and resident files, and tour of the facility. The census at the time of the survey was 10 residents. The bed increase to 16 residents is denied at this time. The following deficiencies were cited: Acronyms which may appear in this report are defined as follows: 45DR(s): DN 45-Day Review(s) **AALM:** Alternate Assisted Living Manager ADLs: Activities of daily living ALM: Assisted Living Manager CDS: Controlled Dangerous Substance(s) CG: Caregiver CN(s): Care note(s) ON: Delegating Nurse EHS: Environmental Health Specialist FA: Manager's Functional Assessment HCPPA: Health Care Practitioner Physical Assessment IOC: Inspection of Care MAR: Medication Administration Record MT: Medication Technician NPA: Nurse Practice Act QA: Quality Assurance RAT: Resident Assessment Tool (consisting of HCPPA, FA, and ST; or Pilot RAT) SP: Service Plan	E 000		

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MAPLE Rll>GE GROUP HOME	15908 MAPLE RIDGE CT ROCKVILLE, MD 20853

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E:1 750	.09 A,B,C .09 Llcensure Standards Waiver .09 Licensure Standards Waiver. A. The Department may grant an assisted living program a waiver from the licensure requirements of this chapter with, or without, conditions. 8. The Department may not, however, grant a waiver from the requirements of Regulation .221 of this chapter. If, however, two Individuals having a long-term or otherwise significant relationship wish to be admitted to a program In order to reside in the program together, and one of the Individuals requires care as defined in Regulation .221 of this chapter, the Department may grant a waiver consistent wllh the process established In l egulation .22 of this chapter. C. Application for Licensure Standards Waiver. (1) A licensee shall submit a request for a waiver 1mder this regulation on a form developed by the Department. (2) The requester shall provide in writing: (a) The regulation frorn which a waiver Is sought; (b) The reason the licensees unable to comply with the regulation; (c) The reason that compliance with the regulation will Impose a substantial hardship; and (d) The reason that a waiver will not adversely affect residents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to request a licensure waiver to allow a resident to sleep in a recliner instead of a bed. Findings include:	E1750	**POC E1750** 1. A waiver will be filed to allow the resident to sleep in a recliner instead of a bed (per request of resident, family & physician). 2. The ALM will request waivers in the future for any other residents requesting to sleep in a recliner instead of a bed. 3. The ALM will be responsible for ensuring waivers are obtained, 4. The waiver will be filed no later than 12/31/17.	2/3/18

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E1750	Continued From page 2 Review of **SP** dated 3/18/17 determined that Resident #2 refused to sleep In a bed, sleeping Instead in a recliner in the llvlhg room every night. During interview with the ALM on 6/20/17, the surveyor asked whether the facility had filed for a waiver for this arrangement,and she stated no.	E1750	**POC E1880** 1. ALM and AALM CEU's will be kept up to date and on-site for review in the Inspection Binder. 2. The AALM will make sure to obtain copies of current certificates after CEU completion and make sure they are on-site. AALM will review CEU's quarterly and keep a chart to track completion of hours. 3. The AALM will be responsible for monitoring this. 4. The deficiency has already been corrected and all CEU's are on-site and available for review.	1/17
e:1880	.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 deslgnee. (b) Except for the records permitted to be stored off-site, a licensee or licensee's deslgnee shall 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 t11e 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.	E1880		

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E1880	Continued From page 3 This REQUIREMENT Is not met as evidenced by: Based on record review and Interview, the ALM failed to maintain her CEU records onsite to be Immediately available for review. Findings Include: The surveyor requested to review the ALM's CEUs on 6/20/17 but they were not available onsite. The ALM emailed the records to the surveyor on 6/23/17.	E1880	POC E2000 1. A new form has been created to document each resident's change in status, service plan review, pharmacy review, outcome of review, and follow-up. 2. We *will* utilize this new form for meetings. In addition, we will utilize fall tracking logs for residents to discuss trends at meeting. 3. The ALM will be responsible for making sure the meetings are wcl I documented. 4. This has already been corrected and will be used at our next QA meeting scheduled for November 2017,	I t/3//9
E2000	.1 3 A .13 Administration .13 Administration. A. Quality Assurance. (1) The assisted living program shall develop and Implement a quality assurance plan. (2) Quality Ass1.1rance Pl an. (a) The assisted living manager and the delegating nurse shall meet at least every 6 months to review the: (I) Change In status of theprogram's residents; (ii) Outcomes of pharmacy reviews; (Iii) Service plan requirements; and (iv) Written recommendations or findings of the consultant pharmacist, as required by Regulation .291 of this chapter. (b) The assisted living manager shall document the proceedings of the meeting referred to in §A(2)(a) of this regulation. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	E2000		

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E2000	Continued From page 4 failed to implement their QA plan so as to show evidence that each resident was reviewed at least every 6 months for change in status, pharmacy review outcome, service plan requirements, and written recommendations made by the consultant pharmacist This was true for 1O of 1O residents at this facility. Findings Include: Review of the facility's QA meeting conducted on 6/5/17 determined that this meeting failed to show any evidence that each of this facility's residents was reviewed for changes in status, outcomes of pharmacy reviews, service plan requirements, and written recommendations/findings of the consultant pharmacist. Meeting documentation was generic and superficial; names of the facility's residents were not even listed. Selected examples include the following: 1. The documentation for the category "Resident Change In Status, including: doctors visits, ER visits, hospitalizations, poor intake, change in mental status, change in behavioral status, physical decline. Service Plan review" read only (appears here as originally written) "Review service plans, on resident who are fall risk and sudden decline In mental status". 2. The documentation for the category "Incident Report Analysls" read only "Several falls across the five houses without serious injuries." During interview with the AALM on 6/20/17, the surveyor asked about the lack of individual resident reviews, and the AALM stated that when they meet they talk about all five houses at one meeting.	E2000		

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E2000	Continued From page 5 There was therefore no documentation to support that individual residents were receiving reviews in the areas required by this COMAR.	E2000	**POC E2560** 1. A MD Statewide background check was completed for the AALM during the survey on 6/20/17. 2. The AALM currently completes a MD Statewide background check on all employees, in addition to other states they have resided. It was an oversight by the previous owner that a MD statewide was not done for the AALM. A review was completed on all other employees on 6/20/17 and confirmed all other staff had a MD Statewide CBC. 3. The AALM will continue to be responsible for ensuring this is done. 4. The deficiency has already been corrected and has been in place since the AALM was hired in 2011.	6/20/17
E:2560	.19 B3 .19 Other Staff--Qualifications (3) Have no criminal convictions or criminal history that indicates behavior that is potentially harmful to residents, as evidenced through a criminal background check completed within 30 days before employment; This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure the completion of a Maryland statewide criminal background check on the AALM. Findings include: On 6/20/17, review of the AALM's criminal background check dated 6/2/11 determined that It had been conducted for Washington, DC only. The AALM delivered a Maryland statewide background check to the surveyor later lh the day; however, this was done after the survey started.	E2560		
E:rn7o	.19 G1,2 .19 Other Staff--Qualifications G. Training In Cognitive Impairment and Mental Illness. (1) When job duties involve the provision of personal care services as described in Regulation .28b of this chapter, employees shall receive a minimum of 5 hours of training on cognitive Impairment and mental Illness within the first 90 days of employment. (2) The training shall be designed to meet the	E2670		

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E2670	Continued From page 6 specific needs of the program's population as determined by the assisted living manager including the following as appropriate: (a) An overview of the following: (i) A description of normal aging and conditions causing cognitive impairment; (ii) A description of normal aging and conditions causing mental illness; (Iii) Risk factors for cognitive Impairment; (iv) Risk factors for mental illness; (v) Health conditions that affect cognitive impairment; (vi) Health conditions that affect mental illness; {vii) Early identification of and intervention for cognitive impairment; (viii) Early Identification of and intervention for mental illness; and {Ix) Procedures for reporting cognitive, behavioral, and mood changes; (b) Effective communication Including: (i) The effect of cognitive impairment on expressive and receptive communication; {II) The effect of mental illness on expressive and receptive communication; {iii) Effective verbal, nonverbal, tone and volume of voice, and word choice techniques; and {iv) Environmental stimuli and influences on communication; (c) Behavioral intervention Including: (l) Identifying and interpreting behavioral symptoms; (II) Problem solving for appropriate intervention; (ill) Risk factors and safety precautions to protect the Individual and other residents; and (Iv) De-escalation techniques;	E2670	**POC E2670** 1. An online training system was implemented for all new hires to receive the 5 hours of initial training in cognitive impairment and mental illness. 2. All new employees will complete the required training within 90 days of hire, and a copy of the training certificate will be kept in the inspection binder at each home. 3. The HR Manager will ensure they complete th(training and that the certificate of completion is in the inspection binder. 4. The new online training system (OHCQ approved vendor, LTC Training Center) was implemented in September 2017 for all new hires.	10/10(17

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E2670	Continued From page 7 (d) Making activities meaningful Including: (i) Understanding the therapeutic role of activities; (Ii) Creating opportunities for productive, leisure, and self-care actlvltles; and (ill) Structuring the day; (e) Staff and family interaction Including: (I) Building a partnership for goal-directed carej (11) Understanding families needs; and (Ill) Effective communication between family and staff; (f) End of life care Including: (i) Pain management; (ii) Prov.idlng comfort and dignity; and (Ill) Supporting the family; and (g) Managing staff stress Including: (I) Understanding the impact of stress on job performance, staff relations, and overall facility environment; (II) Identification of stress triggers; (Ill) Self-care skills; (iv) De-escalation techniques; and (v) Devising support systems and action plans. This REQUIREMENT is not met as evidenced by: Based on record review and Interview, the facility falled to provide evidence that all newly hlred direct-care staff maintained 5 hours of Initial training in cognitive Impairment and mental Illness wltl1in their first 90 days of employment. This was true for 1 of 2 newly hired staff (Staff B). Findings include: Review of Staff B, as well as interview with the AALM, determined that the staff was given a	E2670		

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E2670	Continued From page 8 training package for cognitive impairment and mental illness on 2/27/17; however, no finish date was recorded.	E2670		
E:2780	.20 C .20 Delegating Nurse C. Duties. The delegating nurse shall; (1) Ba 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 livlng 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 record review, the DN failed to exercise the clinical oversight of resident care. This was true for 2 of 2 residents (Residents #1, 2). Findings Include: 1. Review of Resident #1 determined the following:	E2780	**POC E2780** 1. Every new resident will have a RAT done by the DN regardless of whether or not an existing RAT done by a healthcare provider accompanies the new resident. 2. The ALM will review the RAT for any discrepancies. If they are noted, PCP will be contacted for clarification. 3. The ALM will ensure this is done. 4, The practice went into place 10/1/17.	1/1/17

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E2780	Continued From page 9 A. Resident's Pilot RAT dated 7/11/16 was completed by a physician. The DN failed to complete her own comprehensive nursing assessment of the resident as well as reconcile numerous discrepancies which were noted during review of the physician's RAT and associa ted documentation. Examples are as follows: (a) The Pilot RAT documented that the resident did not have constipation; however, per the June, 2017 **MAR,** the resident was being treated for constipation. (b) The admission Pilot RAT and physician's letter from 7/11/16 both documented that the resident had high blood pressure. However, review of the physician's orders from the time of admission as well as the current MAR show that the resident did not take any blood pressure medications, either then or now. (c) The Pilot RAT's Diet/Nutrition section failed to answer a question asking If the resident had any condition which would Impair chewing, eating, or swallowing However, per physician's letter dated dated 7/11/16, the physician documented that the resident had a mild swallowing problem and this placed the resident at high risk for breathing food/liquid Into their airways. (d) Both the Pilot RAT and the physician's letter documented that the resident was insl!lin-dependent. However, per the physician's admission orders the resident was not prescribed any Insulin then: and per the resident's current MAR the resident Is still not prescribed any insulin. (a) Review of the Pliot RAT determined that the	E2780		

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E2780	Continued From page 10 only allergies listed for the resident were two drugs, However, review of the physician's original orders determined that the resident was also allergic to dust and cockroaches, however these allergies were not documented on the Pilot RAT or on the June, 2017 MAR. Therefore, the ON failed to ensure that the resident was appropriately assessed for allergies to food and environmental factors, in addition to drugs. B. The resident's SP dated 2/4/17 was not individualized and/or was inconsistent with the resident's record. See Tag 3320. C. The ON failed to ensure the correct recording of narcotic drugs by staff. See Tag 3710. 2. Review of Resident #2 determined the ON failed to ensure the following: A. That she completed her own assessment of the resident. See Tag 3470. B. To ensure that the resident was assessed at least annually. See Tag 3330, C. To ensure that a complete allergy assessment was performed. See Tag 3330. D. To ensure that all diagnoses were documented. Review of the resident's June, 2017 MAR determined that the resident was being treated with medications for Insomnia and constipation; however, these diagnoses failed to appear In the Current Medical Diagnoses section of the resident's Pilot RAT. E. To ensure accuracy of assessment. Pilot RATs dated 3/3/15 and 3/9/16 were reviewed. Both	E2780		

Office of Health Care Quality

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MAPLE RIDGE GROUP HOME	15908 MAPLE RIDGE CT ROCKVILLE, MD 20853

(X4)1D PREFIX IAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC10 N (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIEN(C)	(X5) COMPI.ETE DA1E
E2780	Continued From page 11 state the resident does not have constipation. However , review of resident's June, 2017 MAR determined that the resident is being treated by medication for constipation . D. To obtain and reconcile medication orders. See Tag 3680. E. To perform a review of the resident's RAT at least every 6 months. See Tag 3350. F. To ensure an individualized SP. See Tag 3330 .	E2780		
E3320	.26 A .26 Service Plan .26 Service Plan. A. The assisted living manager, or deslgnee, shall ensure that all services are provided in a manner that respects and enhances the dignity, privacy, and independence of each resident. A service plan for each resident shall be developed in a manner thc1t enhances the principles of dignity, privac y, resident choice, resident capabilities, individuality, and Independence without compromising the health or reasonable safety of other residents. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure that SPs were individualized. This was true for 2 of 2 residents (Residents #1, 2). Findings Include: 1. Review of Resident #1's SP dated 2/4/17 determined the following:	E3320		

STAfF:MENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X·I) PROVIUER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL001812	A. BUILDING:_____ 8, ING --------	06/20/2017

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E3320	Continued From page 12 (a) Resident's RAT documented high blood pressure. The SP Interventio was to give "medlcE!tlon as ordered"; however, resident Is not ordered any medication for high blood pressure. (b) Review of resident's June, 2017 MAR and RAT from 7/11/16 determined that the resident did not have a diagnosis of current depression and took no medication for depressionHowever, depression was listed as a diagnosis on the SP along with the Intervention of "Meds as ordered." In addition, the Depression section of the SP was left blank (requires to be marked whether Never, Occasional, Regularly, or Continuously). (c) Sleep apnea was listed as a past diagnosis on resident's RAT, and there were no orders for It In the resident's record. Review of the SP, however, determined that sleep apnea was listed as a current diagnosis with Interven tl.ons for "Follow physician's orders" and "Meds as ordered". Additionally, another Intervention directed staff to check the resident's oxygenation level without Indicating any parameters or Instructions for them to follow. (d) The SP states resident has hyperllpldemla and that resident should follow a diet modification, if ordered by the physician. However, the physician did not order any modification, so this Intervention Is not applicable to this resident. (e) Resident has ,m Intervention to give medication for osteoporosis; however, resident Is not ordered any such medication, (f) Instructions for resident's diet do not appear on the SP. RAT dated 7/11/16 documented that the resident needed a diabetic/no concentrated	E3320	**POC E3320** 1. The ALM will conduct a review of all service plans every six months individualizing as necessary or as changes occur. 2. The ALM will review and ensure every resident has an individualized service plan consistent with their needs and reflective of their diagnoses. 3. The ALM will be responsible for ensuring this is done. 4. This will be completed by 12/3 l/17.	I?.J 1161

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E3320	Continued From page 13 sweets, mechanical soft diet. Physician's letter dated 7/11/16 also documented that resident had a mild swallowing problem which placed the resident at high risk for breathing food/liquid into their airways. However, none of this appears on the SP. 2. Review of Resident #2's SP dated 3/18/17 determined the following: {a) Resident's SP listed a diagnosis of osteoporosis with the intervention "Medication as ordered." However, this resident does not take any medication for osteoporosis.	E3320		
E3330	.26 81,2 .26 Service Plan 13. 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 record review, the facility failed to complete full assessments on Its residents and to ensure assessment at least annually. This was true for 1 of 2 residents (Resident #2). Findings include:	E3330		

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STATEMENT OF DEFICIENCIC:S AND PLAN OF CORRECTION	(XI) PROVIDcK/I:iUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E3330	Continued From page 14 1. Resident#1's assessm ent was Incomplete. The allergy section of Resident #1's PIiot RAT dated 7/11/16 lists 2 drugs. However, review of the physician's original orders determined that the resident was also allergic to dust and cockroaches , however these allergies were not documented on the PIiot RAT or on the June, .2017 MAR. Therefore, the DN failed to ensure that the resident was appropriatelyassessed for allergies to food and environmental factors, in addltlo.n to drugs. :2. The allergy section of Resident **#2's** Pilot RAT dated 3/9/16 only listed 2 drug allergies. There was no documented evidence that the resident was assessed for allergies to food or onvironmental factors, and therefore the assessment was Incomplete. 11. On 6/20/17, the latest Pilot RAT for Resident #2 was dated 3/9/16. It was therefore overdue for c:ompletlon at least annually. 4, Resident #1's SP dated 2/4/17 stated resident's code status as "MOLST," which Is not valid for code status. 5. Review of Resident #2's SP dated 3/18/17 determined the following: (a) Resident Is documented as having osteoporosis, with the intervention "Medication as ordered"; however, the resident does not take any medication for osteoporosis. (b) The Bathing section of the SP falls to document for staff that specific medication is available in case resistance is shown to bathing. (c:) In the Depression or Withdrawn Behaviors	E3330	**POC E3330** 1. Upon admission, a complete RAT will be done by the DN regardless of whether or not an existing RAT done by a healthcare provider accompanies the new resident. 2. The RAT will be updated on an annual basis, at the time of a significant change in a status and/or upon transfer to and from another facility. Please note that for Resident #2, there is a completed annual assessment done on 3/9/ l 7. 3. The DN will be responsible for completing the RAT and making sure they are up to date. 4. This practice went into effect 8/1/2017.	zj,/11

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E3330	Continued From page 15 section both "Never" and "Continuous" are checked.	E3330		
E3350	.26 B4,5 .26 Service Plan (4) A review of the assessment shall be conducted every 6 months for residents who do not have a change In condition, Further evaluation by a health care practitioner Is required and changes shall be made to the resident's service plan, If there Is a score change In any of the following areas: (a) Cognitive and behavioral status; (b) Abllllly to self-administer medications; and (c) Behaviors and communication. (5) If the resident's previous assessment did not Indicate the need for awake overnight staff, each full assessment or review of tt,e full assessment shall Include documentation as to whether awake overnight staff Is required due to a change In the resident's condition, This REQUIREMENT Is not met as evidenced by: Based on record review, the facility failed to review residents with condition changes every 6 mohths. This was true for 1 of 2 residents (Resident #2). Findings Include: Review of Resident #2's Pliot RAT dated 3/9/16 determined that It was not reviewed 6 months later, as the 6-month review section was left blank,	E3350	**POC E3350** 1. The DN will review all charts every six months to ensure all changes in patient status have been noted, updated and incorporated into the service plan. 2. The DN will conduct a review of the charts every 6 months. 3. The DN will be responsible to ensure this is done. 4. This will be completed by 12/31/17.	12/31/17
E3470	.28 C ,28 Services C, Nursing Services, The assisted living	E3470		

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E3470	Continued From page 16 manager, In consultation with the delegating nurse, 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 record review, the ALM and DN failed to ensure that: (1) the DN completed her own assessment of residents whose admission RATs were completed by someone else; and (2) recent competencies were completed by the DN on all unlicensed staff. This was tn.ie for 2 of 2 residents (Residents #1, 2); and 2 of 4 staff reviewed for competencies (Staff A, B). Findings include: 1. Resident review determined the following: (a) Reslident #1's Pilot RAT dated 7/11/16 was completed by a physician. The DN failed to complete her own comprehensive nursing assessment, as required by the NPA. (b) Resident #2's Pilot RAT dated 3/3/15 was completed by a nurse practitioner. The DN failed to complete her own comprehensive nursing assessment, as required by the NPA. 2. Review of staff determined the following : (a) Staff A (MT) : A competency was completed on this staff on 3/31/15 for ADLs, vital signs, and blood sugar cheeks. No medication administration competency was completed. (b) Staff C (CG): A competency for ADLs was completed in May, 2017 (c) Staff D (MT, CNA). There were no recent competencies on this staff, The DN last	E3470	**POC E3470-.28C 1** 1. All new residents will have a complete RAT done by the DN regardless of whether or not an existing RAT done by a healthcare provider accompanies a new residents, 2. The DN will review the RAT for any discrepancies. If any are noted, the PCP will be contacted for clarification. 3. The DN will be responsible for ensuring this is done. 4. This went into effect 10/1/17, It encompasses the following; the day of admission, return from hospital or LTC facility or after a significant change in status.	11/17

STATEMENT Of LJI:FICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E3470	Continued From page 17 completed a competency for providing ADls, skin checks, and taking vital signs in May, 2012. No medication administration competency had been completed on this staff. During Interview with the ON on 6/20/17, she :stated that she was unaware of this requirement.	E3470	**POC E3470-.28C 2** 1. A form will be utilized to verify competency on all cun-ent CMTs. 2. We will begin annual competency verifications on CMT's, based on hire date. 3. The DN will be responsible for ensuring this is done. 4. This went into effect 10/1/17 and will completed based on date of hire.	10)1)r9-
E3680	.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: Based on record review, the facillty failed to emsure that medications were administered consistent with orders and using professional practice standards. This was true for 2 of 2 residents (Residents #1, 2). Findings Include: 1. Resident #1: A. Review of Resident #1's June, 2017 MAR determined that it contained two orders for the same pain reliever running concurrently. One was a standing order for administration three times a day, and the other was an "as needed" order. These orders appeared on different pages of the MAR with no warning of same tostaff. B. The resident's SP dated 2/4/17 directs staff to apply a moisture barrier cream; however, resident	E3680 c.1\o8'G	**POC E3680-.1A** 1. The ALM will review each MAR upon admission and at the end of every month when new MARS are delivered to facility for accuracy. 2. ALM will confer with pharmacy and prescribers when an order is in question in order to establish clarity and accuracy. This will be done upon adm1ss10n and at the end of every month.	

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E3680	Continued From page 18 does not have an order for this. C. The resident's SP dated 2/4/17 directs staff to crush resident's medications; however, resident does not have an order for this. In addition, there Is no such Instruction marked on resident's June, 2017 MAR. 2. Resident #2: A. Review of the resident's orders as well as June, 2017 MAR determined that the resident had both a standing order and an as-needed order for an anti-anxiety medication. These orders appeared on different pages of the MAR with no warning of same to staff. Additionally, the as-needed order was not transcribed onto the MAR as It was originally written. One of the omissions was the limit on the frequency of administration; and the as-needed order appeared to conflict with the standing orqer. The DN failed to clarify theseorders with the physician and to ensure correct transcription onto the MAR. B. Resident's SP from 3/18/17 documents that medications are to be crushed in Ice cream when resident becomes resistive: however, resident has no order for this, and no such Instruction appears on resident's June, 2017 MAR.	E3680	3. The ALM will be responsible for ensuring this is done. 4. This went into effect 10/1/17. **POC E3680-.1B & C** 1. Contact prescriber's office and obtain an order for moisture barrier cream and order to be able to crush medications. 2. ALM will confer with prescribers in order to obtain orders upon admission or as needed by residents. 3. The ALM will be responsible for ensuring this is done. 4. All orders will be obtained for Moisture barrier cream and to crush meds for any residents as needed by 12/31/17.	0/1/17
E I710	.29 O .29 Medication Management and Administration 0 . Accounting for Narcotic and Controlled Drugs. (1) Staff shall count and record controlled drugs, such as narcotics, before the close of every shift. (2) The dally record shall account for all controlled drugs documented as administered on	E3710		13/17

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E:3710	Continued From page 19 the medication administration record. (3) All Schedule II and Ill narcotics shall be maintained under a double lock system. This REQUIREMENT is not met as evidenced by: Based on record review, the ALM and DN failed to ensure the correct recording of narcotic drugs by staff. This Was true for 1 of 4 narcotic logs reviewed for Resident #2. Findings Include: Review of Resident #2 determined that this resident had 4 narcotic log sheets. One was for an as-needed controlled substance and the other three for standing doses of the same substance. A review of the as-needed controlled substance log determined that the starting quantity of tablets received was 15. However, the log started with a count of 11 Instead of 15. The surveyor requested the facility to ser,d any further logs they may have, however no m0re were received. There was therefore no accounting for the first 4 tablets,	E3710	**POC E3710** 1. The current narcotic log will be adjusted to also have a line that reads "Quantity carried over from previous month". 2. All future narcotic logs will be adjusted. 3. The ALM will be responsible for ensuring that staff understand how to accurately complete the adjusted narcotic log. 4. This will be completed by 12/31/17.	12/31/17
E:3790	.31 C .31 Incident Reports C. All incident reports shall include: (1) Time, date, place, and Individuals present; (2) Complete description of the Incident; (3) Response of the staff at the time; and (4) Notification, Including notification to the: (a) Resident, or if appropriate the resident's representative; (b) Resident's physician, if appropriate; (c) Program's delegating nurse; (d) Licensing or law enforcement authorities, when appropriate; and (e) Follow-up activities, including investigation of	E3790	**POC E3790** 1, All current incident reports will be reviewed by the ALM for accuracy to include: individuals present, notification to the DN, and response of the staff at the time. 2. All future incident reports will be reviewed by the ALM for accuracy of	

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E3790	Continued From page 20 the occurrence and steps to prevent its reoccurrence. This REQUIREMENT Is not met as evidenced by: Based on record review, the facility failed to complete Incident reports as required, This was true for 3 of 3 incident reports, Findings include: Review of 3 incident reports determined the following: 1. Report dated 1/8/17 failed to Include the Individuals present, notification to the DN, and response of the staff at the time. 2. Report dated 1/17/17 failed to include individuals present and response of the staff at the time. 3. Report dated 3/9/17 failed to Include the Individuals present, notification to the DN, and response of the staff at the time.	E3790	completion before being filed. 3. The ALM will be responsible for ensuring this is done. 4. This will be completed by 12/31/17.	2/31/17
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:**	E3960	**POC E3960** 1. A waiver will be filed to allow the resident to sleep in a recliner instead of a bed, according to her preference. 2. The ALM will request waivers in the future for any other residents requesting to sleep in a recliner instead of a bed. 3. The ALM will be responsible for ensuring waivers are obtained. 4. A waiver will be filed for no later than 12/31/17.	12/31/17

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E3960	Continued From page 21 Based on record review and Interview, the facility failed to provide a resident with appropriate care and services when II allowed a resident to sleep In a recliner In the facility's living room every night. Findings Include: Review of SP dated 3/18/17 determined that Resident #2 refused to sleep In a bed, sleeping instead In a recliner in the living room every night. Instead of filing for a waiver to allow the resident to sleep In a recliner In resident's bedroom, affording the resident privacy, the facility allowed the resident to keep sleeping In the living room.	E3960		
E 4630	.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 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. This REQUIREMENT Is not met as evidenced by: Based on ooservatlon, the facility failed to keep the room Intended for a bed increase free of conditions that may create a health hazard. Findings Include: On 6/20/17, the surveyors observed that the room	E4630	**POC E4630** 1. The bed was moved away from the sliding glass doors and window curtains were installed on the sliding glass door. 2. The bed will not be placed in front of glass doors. 3. The ALM will be responsible for ensuring this is always done. 4. The deficiency was corrected on 8/28/17.	12/8/17

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E4630	Continued From page 22 intended for a bed Increase had no windows, but did contain a large sliding glass d0or at one end of the room. The headboard of one of the residents' beds was placed flush with the glass door, and could become a health hazard for a resident in the bed if the glass were broken.	E4630		
E:5340	.49 A9 .49 Resident's Room and Furnishings (9) A resident's room shall have window shades or their equivalent. This REQUIREMENT Is not met as evidenced by: Based on observation, the facility failed to provide window shades or their equivalent In the room Intended for their requested bed Increase. Findings Include: Observation on 6/20/17 determined that the room intended for the facility's requested bed increase had a sliding glass door In lleu of any windows, and that that slider had no covering of any klntj. Additiona lly, since the bed Is next to the slider, t·here Is a question of the slider rendering the room unacceptably cold during cold weather.	E5340	**POC E5340** 1. Full length curtains have been installed. 2. The ALM will be responsible to ensure curtains cover the window. 3. The ALM will be responsible to ensure this will not re occur. 4 The deficiency was corrected on 8/28/17.	1/28/17
E!5350	.49 A10 .49 Resident's Room and Furnishings (10) The assisted living program shall provide adequate closet or wardrobe space, conven iently located to allow each reside nt to keep personal clothing. This REQUIREMENT Is *not* met as evidenced by: Based on observation, the facility failed to provide adequate closet space in the room of the	E5350	**POC E5350** 1. The chest of drawers was relocated in the room and removed from the closet. 2. The ALM will ensure that this will not re occur.	

STAfEMENT OF nFFlr.lF.NCIES AND PLAN OF CORRECTION	(X1) r>ROVIDCR/3UPPLIER/CLIA IDENTIFICATION NUMBER:	\Vi!) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL001812	A.BUILD NG _____ .B WING _____	06/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAI'LE RIDGE GROUP HOME	15908 MAPLE RIDGE CT ROCKVILLE, MD 20853

(X4)ID PREFIX 1AG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECI'ION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(Xii) COMPLETE DATE
E'.5350	Continued From page 23 intended bed increase. Findings Include: On 6/20/17, the surveyors observed that a large chest of drawers was sitting on the floor of the closet in the room intended for the bed Increase. This chest significantly decreased the amount of space available In the closet.	E5350	3. The ALM will be responsible to ensure that this practice does not re occur. 4. The deficiency was corrected on 8/28/17.	5\28\17
E:5370	.49 82,3,4,5,6 .49 Resident's Room and Furnishings (2) A bedside stand with a drawer; (3) A comfortable chair; (4) At least two dresser drawers in a chest of drawers; (5) A bedside or over-the-bed lamp; and (6) A sufficient supply of bath and bed linens. This REQUIREMENT is not met as evidenced by: Based on opservation, the facility failed to provide the l'OOm Intended for a bed increase with 2 comfortable chairs. Findings Include: On 6/20/17, the surveyors observed that the room intended for the bed increase held 2 folding chairs. The chairs' seats had little padding and no arms.	E5370	**POC E5370** 1. Two comfortable chairs with arms were placed in the resident room. 2. The ALM will monitor the room to ensure that this deficiency does not re occur. 3. The ALM will be responsible that this deficiency will not re occur. 4. The deficiency was corrected on 8/28/17.	8\28\17
EU380	.49 C .49 Resident's Room and Furnishings C. A competent resident may waive the resident's right to one or all of the furnishings listed in §8 of this regulation by signing a wavier and having the waiver placed in the resident's record.	E5380		

Office of Health Care Quality

STP.:rEMENT OF DEFICIFNCIES AND PLAN OF CORRECTION	(X1) mOVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL001812	A. BUILDING:_____ B. WIN_G _ _ _ _ _ _ _	06/20/2017

NAME OFPROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAI>LE RIDGE GROUP HOME	15908 MAPLE RIDGE CT ROCKVILLE, MD 20853

(X4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	Io PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X!•) C0MPI.ETE DA1'E
E5380	Continued From page 24 This REQUIREMENT Is not met as evidenced by: Based on record review and Interview, the facllity failecl to obtain a waiver signed by the residenVrepresentative and placed in the resident's chart for the resident to sleep In a recliner Instead of a bed, as required under COMAR 10 .07.14.49(C). Findings include: On 6/20/17, review of SP dated 3/18/17, as well as interview with the ALM, determined that the resident refused to sleep In a bed, sleeping Instead In a recliner In the living room every night. During Interview with the ALM, the surveyor asked whether the facility had the reslden Urepresentatlve sign and place in the resident's record a waiver to sleep In a recliner, and she stated no.	E5380	**POC E5380** 1. A waiver will be filed to allow the resident to sleep in a recliner instead of a bed (per request of resident, family & physician). 2. The ALM will request waivers in the future for any other residents requesting to sleep in a recliner instead of a bed, 3. The ALM will be responsible for ensuring waivers are obtained. 4. The waiver will be filed no later than 12/31/17.	12/31/17

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

Form Approved 4/4/13
DHMH Form ALAPP.1.1

ASSISTED LIVING
APPLICATION FOR LICENSURE

1. GENERAL INFORMATION

10

CHECK TYPE OF APPLICATION

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

LICENSE NUMBER (if applci able}	WEBSITE (if applicable)
LEGAL AGENCY NAME	T /iNG NAME (OBA) ft //}!}PL£ '/?.!l b£ G/0.DLlP !l o?c
E-MAIL ADDRESS s-k.vc,1 h l el/ cl e? a,_,:/. Ccr'Y)	PHONE NUMBER ift/J -0/37 -8 Ffl? FAX NUMBER J00-. C/Sf;-C,19p
BUSINESS ADDRESS (physical location) I r S - m aple. Rt;Jq.!... CC!urT	MAILING ADDRESS (if different) 13o'7 - m£: !l-1£1\/f!./ <!r
NUMBER, STREET	NUMBER, STREET
Wa !L i-£ STATE ml> ZIP Zci5'3- i ,J.3	I, e r 1 yt STATE nl p Z[d'll

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

NUMBER OF RESIDENTS CURRENTLY SERVED	NUMBER OF BEDS REQUESTED	LEVEL OF CARE REQUESTED
I :LJ	I	01 0 2 ff3

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	PHONE NUMBER	CELL NUMBER
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HOME ADDRESS numbe,r street)	CITY	STATE ZfP
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NAME OF ALTERNATE MANAG R	PHONE NUMBER	CELL MUMBER
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HOME ADDRESS number, street)	CITY	STATE ZIP
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NAME OF DELEGATING NURSE (DN)	PHONE NUMBER	CELL NUMBER
Sue Spaulding RN	301-869-7341	240-731-4099
HOME ADDRESS (number, street)	CITY	STATE ZIP
16300 Jousting Terrace Court	Derwood	MD 20855
DN'S LICENSE NUMBER	EXPIRATION DATE OF DN'S LICENSE	
/<._:1,.;J.ltJf.33	ID -;z._ f -Zo/	

Is your facility planning to operate, or currently operating, an "Alzheimer's Special Ca,re nit or Program?" No Yes (refer to the instruction guide for details on submitting your program description)

2. FEES

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

FEE ATTACHED? 0'Yes

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

SOLE PROPRIETORSHIP | PARTNERSHIP | CORPORATION

NAME /J

r' rcnifrL /lh-,v .Z. <!.-

ADDRESS

/ °?e-'7 -4/ #'&J..ef a/t r - t?Pr/ n. 177.P -./)-/ JI/

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

NAMEAND TITLE	E-MAIL	PHONE NUMBER	ADDRESS	% OWNED
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			/Jer/in. mD- .2l&I(	

IF CORPORATION:

DATE OF CHARTER: I - /1..f-.:LtJ / (,

DATE OF INCORPORATION: /-/..,£- :z.o/t,

FEIN NUMBER: Bl-099/3 O

NAME OF PRESIDENT	PHONE NUMBER	CELL NUMBER
6TEVEfi./ 13 J..-iJ YO	'/-ltJ - Cf'3>J - f:3 eB 8	IO· 3/'3/· S,s,'S,s,'
ADDRESS(number, street)		STATE / ZIP
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4. BACKGROUND

1. Has the applicant, owner, or managerial staffever had ense, permit, or certificate to provide care to third parties that has been denied, suspended, or revoked? L!'.'.I 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 0 Yes (explain)

3. Does the owner, applicant, manager, alternate manager, other staff, or any household member have a criminal conviction or other criminal history? 0 No D Yes (explain)

5. WORKERS' COMPENSATION

Do you have any employees? 0 Yes D No

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

POLICY NUMBER: ft,z. 3llo.3

BINDER NUMBER: '-f(p1-3c" 3

INSU Nc;E COMPANY: #45#&/I--- .Qwa,.

EFFECTIVE DATE: Irr

EXPIRATION D TE: 'Jy/r„ /1

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 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,xryJcmisgjrg tobe in m:xe tfa'I me *cp:iicat'snarre, eoch awica1t's sig1Bture is reqtiroc/.*

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