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

Garden House at Edenton
5849 Genesis Lane
Frederick, MD 21703

Characteristics:

- For-Profit Corporation with 15 beds
- Legal Business Name – Closup I, Inc d.b.a. Edenton Retirement Community
- Administrator – RaeAnn Butler
- www.edenton-retirement.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 an assisted living facility should undertake a review of surveys or other data that will provide a snapshot of some of the issues or problems that the facility is experiencing. Keep in mind that this information can be limited and may not reflect the actual condition of the facility when your loved one is admitted. You should consider personal visits of any facility you are evaluating.

The Maryland Department of Health inspects assisted living facilities including the Garden House at Edenton in Frederick, MD. Periodically they do inspections as complaint surveys which should be public record.

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

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

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

2) Fax : 410-402-8179

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

Having already researched Garden House at Edenton in Frederick, 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 Qualit"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10AL011	A. BUILDING B. WING	08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN HOUSE AT EDENTON	5849 GENESIS LANE **FREDERICK, MD 21703**

(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 August 28, 2019 an Inspection of Care (IOC) survey was completed 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 compliance with COMAR regulations 10.07.14, Assisted Living Program Regulations. Survey activities included a review of administrative records, staff records and resident records, interviews with staff members, residents and tour of the facility. The facility's census on August 28, 2019 was eleven residents and the following deficiencies were identified; The following acronyms will appear throughout this report and are defined as followed: 1. Assisted Living Manager (ALM) 2. Director of Nursing (DON) 3. Medication Technicians (MT) 4. Electronic-Medication Administration Record (E-MAR) 5. Office of Health Care Quality (OHCQ) 6. Emergency room (ER)	E 000		
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 whi;m 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 non routlne leaves of absence;	E3420		

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E3420	Continued From Page 1 and (f) When the resident is discharged permnently 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 Resident #1's record review and staff interview on 8-28-2019 the facility failed to ensure a care note was written to describe the resident's elopement from the facility. Findings include: Review of Resident #1's hand written care notes for August 2019 revealed a night shift care note that documented the resident had eloped on day shift. The resident's night shift care note failed to describe the events of the elopement and day shift staff had failed to document the elopement. Computerized care notes for August 2019 were also provided upon request and no documentation was recorded to support the resident's elopement. An interview with the facility's DON 8-28-2019 revealed the information of the elopement was documented In an incident report and on the self-report incident documentation e-m'ail to OHCQ.	E3420	**1.** Staff member counselled regarding proper sequence and location for **care note related to incident. Entry was found to be discontinued on the MAR and not In the correct location. Information provided to surveyor on 9/4/2019.** **2. Deficiency corrected on 9/4/2019.** **3. Nurse on duty will review incident** report and ensure care note was written. **4. Delegating nurse will complete a weekly monitoring tool for review of incident reports.**	
E3680	.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	E3680		

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E3680	Continued From Page 2 of practice. This Requirement is not met as evidenced by: Based on resident record review and staff interview on 8-28-2019 the facility failed to ensure a medication was received as ordered. Findings include: Review of Resident #1's July 2019 nursing n tes and E-MAR for June and July 2019 revealed that the resident's ordered eye health care medication was not available for administration for over a month. An interview with the facility's DON on 8-28-2019 revealed the medication was not provided on admission and the facility had difficulty with obtaining a new physician's order to obtain the medication.	E3680	1. Med tech counselled about charting unavailable medication on MAR without notification to licensed nurse. Delegating nurse counselled regarding delay in clarifying physician order and unavailable medication from pharmacy. 2. Delegating nurse will review physician orders at admission and will ensure that ordered medications are received from the pharmacy at admission. 3. Deficiency corrected on July 16, 2019. 4. Delegating nurse will complete the Admission/Change form to include review and compliance of RAT, medications, care note and plan review. 5. Weekly, DON will review new Admissions/ re-admissions and sign off on admission/change form to ensure completed.	
E3790	.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 the occurrence and steps to prevent its reoccurrence.	E3790		

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E3790	Continued From Page 3 This Requirement is not met as evidenced by: Base on resident record review and staff interview on 8-28-2019 the facility failed to ensure Resident #2's incident reports for December 2019 documented an accurate description of the incident, following up actions taken to monitor resident condition and preventative action taken. Findings include: Review of Resident #2's care notes revealed two falls had occurred in the last week of December 2018 and the following deficient practices were found upon review of the incident reports: A. The resident 's first December 2019 incident report failed to document a complete description of the incident and witnesses were identified on the incident report. The incident report documented that the resident hit their head. A set of vital signs was documented but no other staff intervention was noted to support an adequate assessment of the resident's condition was completed. Continue to observe was the follow-up intervention documented on the incident report. B. The resident's second December 2019 incident report failed to document an adequate description of the resident's condition. The incident report documented the resident did not hit their head and also documented that the resident sustain an injury to the head. No follow-up action was documented to support staff monitoring upon resident's return from the ER and no preventative action documented. An interview with the DON on 8-28-2019 revealed the facility has a policy for staff to complete neurological checks after a head injury occurs. The DON acknowledged that the facility had no documentation to support neurological checks	E3790	1. Staff in-serviced on proper completion of incident reports. Staff educated to consult with ORN or licensed nurse to ensure adequate assessment of the resident's condition following an incident involving a head injury. 2. Deficiency corrected with staff education on 8/29/2019 3. Incident reports will be reviewed by nurse on duty to ensure form, assessment and follow up Intervention is completed. Monitoring tool will be completed weekly by nurse 4. Administrator will review incident reports quarterly for quality **assurance review and reporting** at meeting.	

Office of Health Care Quality

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E3790	Continued From Page 4 were initiated. Both incident reports were reviewed with the DON on 8-28-2019 and additional documentation was e-mailed on 8-29-2019 from the DON. The received documentation did not change the deficient practices documented above.	E3790		

(i! \ **MARYLAND**
Department of Health

Lan:v Hogan. C0 Fe r 11or · B o yd K. Ruth e ,:fo rd, Lt. C ove m or · Robert R. Neall. Secreta ,y

October 10, 2018

Rae Ann Butler
Assiste d Living Manager
Garden Ho use Al Edenton
5849 Genes is Lane
Frederick, MD 21703-5117

RE: PLAN OF CORRECTION APPROVED

Dear Ms. Rae Ann Butler:

We have accepted the Plan of Correctio n (PoC) submitted as a result of the January I9, 20I 8 Inspection of Care survey of your facility.

An una nnounced follow -up visi t may be conducted to ensure continual compliance based on current regulatory standards and your proposed PoC.

Please contact Surveyor Nurse Teresa Tighe at teresa.tighe@maryland.govor 667-209-0266 with any questions.

Sincerely,

Carol Fenderson

Carol Fenderson
Deputy Director, State Programs

Cc: File
Facility #I0AL011

Office of Health Care Qualif

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E000	Initial Comments On January 19, 2018 an Inspection of Care (IOC) survey was completed 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 compliance with COMAR regulations 10.07.14, Assisted Living Program Regulations. Survey activities included a review of select administrative records, staff records and resident records, interviews with staff and four of the facility. The facility's census on January 19, 2010 was eleven residents. The following deficiencies were identified;	E000		
E2600	10.19.86.19 Other Staff--Qualifications (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; (g) The [illegible] a se smerit process; (c) The use of service plans; and (d) Resident's rights; and This REQUIREMENT is not met as evidenced by: Based on staff record reviews, staffing schedule and Interview with facility staff, the facility failed to	E2600	E2600 1. Staff completed First Aid certification class on 1/26/2018. Other courses were completed on 1/21/2018. 2. The human resource coordinator completed an audit of the employee file and employee was notified to complete required topics on the web based training program by 1/26/2018. 3. Employees are provided detailed Information about the required training topics at orientation and quarterly each year with updated notification about what topics are outstanding to date. 4. The human resource coordinator will conduct quarterly audits of the training records and notify staff of missing topics. 5. Facility was compliant by January 21 2018	

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

FORM CMS-2567(02-99) 940311 ?12-7 If continuation sheet 1 of 10

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STATEMENT OF DEFICIENCIES I.. NO PLAN OF CORRECTION	(XI) PROVIOERtSUPPLIER/CLIA IOENTIFIC/\TION NUMBER	(X2) MULTIPLE CONSTRUCTION A.BUI LDN G: _____	(X3) DATE SURVEY COMPLETED
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E2600	Continued From page 1 ensure Initial training requirements were met prior to a new staff member being placed on duty as one of the two staff members providing resident care. Findings include: Review of Staff 's training record revealed the staff member file failed to have documentation to support the following ir)ilial trainings; 1. Basic first aid by a certified first aid instructor 2. 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. interview with the facility's Human Resource Manager revealed that the facility did not have supporting Documentation for the missing training that's documented above.	E260D		
E3350	.26 84,5.26 Service Plan (4) A review of the assessment shall be conducted every 6 months for resident s 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 followlng areas: (a) Cognitive and behavioral status; (b) Ability 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 the full assessment shall include documentation as to whether awake overnight staff is required due to a change In the	E3350	E3350 1. ORN completed documents required for six month review. Signature and date was not placed on HCPPAF 2. ORN or ORN designee will review the resident record during the completion of the ORN 45 day review. If a full assessment has not occurred for a resident during the prior six(6) months, the ORN will review the resident assessment and document that the HCPPAF was reviewed. The review will be documented in the 45 day ORN review document, HCPPAF and service plan. ORN or DRN designee will have completed a review of all current residents and determine need for a resident assessment review during the completion of the Residents 45 day reviews. Reviews to be completed by February 28 2018. 4. Director of Nursing will review Resident records quarterly to ensure documentation Is present for review and the notation of review is recorded by initials or signature in multi ple places.	

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E3350	Continued From page 2 resident's condition. This REQUIREMENT is not met as evidenced by: Based on staff interview and reside!'ll record reviews the facility failed to complete a six month review of a resident's Health Care Practitio·ner Physical Assessment Form (HCPPAF) as required. Findings include: Review of Resident #1's record and interview with the Deleg ting Nurse revealed that the six month review or the resident's HCPPAF was not completed as required.	E3350		
E3 8D 29 N 29	Medication Management and Administration .29 Medication Management and Administration. N. Medications and treatments shall be administered consistent with current sig11ed medical orders and using professional standards of practice. This REQUIREMENT is not met as evidenced by: Based on resident record review and interview with staff revealed the facility failed to ensure medication & treatment orders were followed and medications were administered as ordered. Findings include: Resident #1 The resident's record review r v aled the	E3680		

STATEMENT OF DEFICIENCIES ANO PLAN OFCORRECTION	(XI) PROVOER/SUPPll ER/CUA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E3680	j Continued From page 3 resident's diagnoses includes high risk disorder with specific monitoring intention to be completed twice a day and the physician i$ to be notified if the testng results are above or below set parameters. The following documentation are examples of deficient practices found: a.) Review of th-e residenl'.s current and previous MAR revealed that the facility staff failed to document the completion of the resident's ordered specific monitoring intervention five times. No documentation was found *on* the resident's MARs to support why the specific monitoring was omitted. t he missing documentationwas reviewedwith the Delegating Nurse (ON) and License Practical Nurse (LPN) and no additional information was provided. b.) Review of the resident's current MAR for results related to the specific testing that is to be completed twice a day revealed the resident's level were above the set parameters four times. The residenl'scurrent MAR and care notes failed to document that the physician was called as ordered for the high levels. Review of the findings with the Delegating Nurse (ON) and ll cense Practical Nurse (LPN) revealed no additional information 10 support compliance with physician orders. c.) Review of the resident's physician assessment completed in the first week of Jan uar-y2018 revealed a few order changes to the resident's diet. specific monitoring frequency and ordered parameters. Review cif the resident's current MAR revealed that noorder changes were documented after the physlci,,m's assessment. Interview with the facility's LPN revealed that once the resident's family member submitted the physician's assessment for review, the physician was called about the new orders. The physician repo rtedly ins tru ctedthe LPN to disregard the new orders that were written *on* resi ent's	E3680	E3680 1. Deficiency correctedby: Resident1#1a. Med techs were counseled regarding completion of medication admin tasks and charting of vitals. They were also counseled regarding notification of a nurse when a parameter Is exceeded so that nurse can contacta physician. b. Med techcounseled regarding steps for 3 way medication checks and process for receiving medication from resident/family.Med Techto report to nurse when wrong medication supplied by family. c. Verbalorder for diet change corrected during survey. Resident1#2a. Med techsresponsible for datesof med administration noted were disciplined for failure to notifynurse that medication was not delivered by pharmacy. 2. Delegating Nurse or ORN deslgnee will review medication administration records to ensure that medications and treatments are received and administered as ordered and documented. The delegating nurse or nurse deslgnee wlll reviewdally/shift the medication orders (new, changes and DC'd) MAR and POS for accurate documentation practices and correct orders. Nurses will ensure that verbal and telephone orders will be documented In the chart. 3. ORN willl nclude medication changes in 45 day revie w process. 4. Delegating nurse or DRN deslgnee will apply disciplinary action to medication technicians and nurses who fall to document medication administration and treatments, unavailable medications and problems with medications in accordance to regulations. 5. Director of nursing will review resident records quarterly to monitor completeness of medication administration documentation. Compliant by October 1 2018.	

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E3680	Continued From page 4 January 2018 physician assessment. The LPN acknowledged that the verbal order to discontinue the changes on the physician assessment was not documented at the time of receiving. d.) Review of the resident's January 2018 doctors' visit *form* revealed an order for a supplement. The dose of the supplement was documented as 1500 mg twice a day. The order was reviewed with the ON to ensure dose amount. Review of the resident's January 2018 **MAR** revealed the first transcription of the supplement was documented at 1300 mg twice a day and it was documented as administered for seven days and then discontinued. The second time the supplement was transcribed onto the current MAR it's dose was documented to be 1400 mg twice a day. No additional orders were found for the supplement at the time of the resident's record review and review of the dose error with the Delegating Nurse (ON) a1_1d license Practical Nurse (LPN) revealed no additional clarification of dose. Resident #2 Refer to resident's rights Tag #3960 for inadequate treatment.	E3680		
E3790	.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 ta the: (a) Resident, or if appropriate the resident's representative; (b) Residen'ts physician, if appropriate; (c) Program's delegating nurse;	E3790		

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E3790	Continued From page 5 (d) Licensing or law enforcement authorities, when appropriate; and (e) Follow-up activities, including investigation of the occurrence and steps to prevent its reoccurrence. This REQUIREMENT is not met as evidenced by: Based on resident record review and staff interview the facility failed to ensure incident reports documented a clear description of even\s that had occurred. Findings include: Review on five incident reports revealed that one of five incident reports failed to have a designated area to document the events of the resident's fall *and* therefore a clec;1r description was not documented by facility staff. Interview with facility's Delegtlng Nurse revealed that additional information was written in the resident's care notes, but not on the incident report	E3790	E3790 1. Incident reports will be completed by the staff member in its entirety following notification or finding of Incident. Staff inserviced on proper completion of incident reports. Staff educated to consult with DRN or licensed nurse to write in additional information on incident report once printed from computer to append. 2. Staff member will clearly state the facts of the fall or incident. 3. Incident reports will be reviewed by nurse on duty following incident to ensure form and actions were completed by staff members. Reviews conducted on 1/20/2018. Facility compliant by March Jo 2018 4. DRN will assign a weekly review of incident reports to a licensed nurse. DRN will be notified by licensed nurse of any problems with uncompleted reports, weekly. 5. Administrator will review incident reports quarterly for quality assurance review and reporting at meeting.	
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 service s that are adequate, appropriate, and in compliance with rele vant State, local, and federal laws and regulations:	E3960		

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GARDEN HOUSE AT EDENTON	5849 GENESIS LANE FREDERICK, MD 21703

(X4) 10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PRIFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
E3960	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview with facility staff and resident record review the facility staff failed to ensure a resident received adequate treatment. Findings include: Review of Resident #2's physician order sheets (POS), current medication administration records (MAR) and blood work results revealed the facility staff failed to ensure the resident's high risk blood thinner was administered as ordered. The resident's current MAR documented that the resident did not receive the blood thinner for three days. The resident's specific testing that was completed revealed a dropped in the resident's level that was well below therapeutic range identified by the resident's physician. Interview with the Delegating Nurse (ON) during the resident's record review revealed staff at the facility had not informed the DN that the resident's blood thinner was not available.	E3960	E3960 1. Resident 112 Med techs responsible for dates of med administration noted were disciplined Jan 20 2018 for failure to notify nurse that medication was not delivered by pharmacy. 2. ORN or ORN designee will ensure that a residents receiving treatment and care as ordered by the resident physician. 3. Delegating Nurse or ORN designee will review medication administration *records* to ensure that medications and treatments are received and administered as ordered and documented. 4. Delegating nurse or DRN designee will apply disciplinary action to medication technicians and nurses who fail to document medication administration and treatments, unavailable medications and problems with medications In accordance to regulations. S. Director of nursing will review resident records quarterly to monitor completeness of medication administration documentation. Corrected by 10/1/2018	
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 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 Qlialit

STATEMENTOFDEFICIENCIES ANOPLAN *OF* CORRECTION	(X1) PROVIOER/SUPPLIERICLIA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATESURVEY COMPLETED
	10AL011	A BUILDING _____ B. WING _____	01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZIP CODE
GARDEN HOUSEATEDENTON	5849 GENESIS LANE FREDERICK, MD 1703

(X4) ID PREFIX TAG	SUMMARY STATEMENT *OF* DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULi. REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PIANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E4630	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation during the tour of ihe facility and interview with facility staff, ttie facility failed to ensure th facility was Kept free of any object or conditions that may create a health hazard. Findings include; 1. Staff t/.1 acknowledged that there were no bathroom·s in any of the residents' bedrooms and all bathrooms were shared by the facility's residents. Observation of the first bathroom which was identified as bathroom #1 revealed a wall soap dispenser *and* two bath towels and two hand towels for all residents to use. Staff #1 stated that the facility has a resident who lakes and misuses any paper towels that may be lert within the bathrooms. The facility obtains their residents three meals from a central kitchen and the central kitchen supplies meals to all of Ihe Edenton facilities. Therefore, the facility is responsible for complying with food standards for a commercial kitchen, such as taking food temperatures prior to serving meals to the residents. Review of food logs maintained at the facility revealed food temperatures had not been completed for each meal as required. The following findings acknowledge how many days the facility staff failed to complete food temperature logs: a.) Five out of nineteen days in January 2018 b.) Fourteen out of thirty one days in December , 2017 c.) Eighteen out of thirty days in November 2017 The facility's Delegating Nurse was informed of the abqve deficient practic::e and offered no	E4630	E 4630 1. a. Hand towels are replaced dally in bathrooms used by residents. Disposable paper towels are In the two handicap bathroom receptacles. Additional paper towel units will be installed in the other six bathrooms. b. facility staff counseled regarding the necessity of logging food temperatures for each meal as required by the county health dept. 2. Deficiency corrected on 9/19/2018. Awaiting order of mountable paper towel dispenser for 6 bathrooms 3. Staff trained to complete tasks as described above. Document food temps when received per meal on provided log sheets. Maintain paper towelsI in bathrooms for use. 4. Administrator will be responsible for ensuring compliance of the plan.	

0 fice of Health Care Quahh

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOEfVSUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPI.ETEO
	10AL011	A BU|LDIN G _____ OING _ _ _ _ _ _ _ _	01/19/2018

NAMEOF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE, ZIP CODE
GARDEN HOUSEAT EDENTON	**5B49 GENESIS LANE** FREDERICK, **MD 21703**

(X4)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (I:JICH DEFICIENCY MUST OE PRECEDED]]VFULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TA.G	PROVIDER'S PLANOF CORRECTION (1:ACII CORRECTIVE ACTION SHOULD BE CRoss REFERENCED TO THE APPROPRIATE ciEFICIENCY)	(XS) COMPIETE DATE
E4630	Continued From page 8 additional documentation to support compliance.	E4630		
E4910 .46	E3 .46 Emergency Preparedness (3) Semiannual Disaster Drill. (a) The assisted living program shall conduct a semiannual efl1ergency and disaster drill *on* all shifts during which ii practices evacuating residents or sheltering in-place so that each is practiced al least one lime a year. (b) The drills may be conducted via a table-top exercise if the program can demonstrate that moving residents willbe 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. This REQUIREMENT is not met as evidenced by: Based on review of the facility's administrative records and interview with' staff, the facility failed to provide semiannual emegency/disaster drills (Evacuation & Sheller in Place) for all shirts.in 2017. Findings include: Review o-f the facility'swe & disaster drill book revealed no evacuation drill sheets for 2017. Interview with the facility's maintenance man	E4910	E4910 1. Once survey results were received by facility on 9/11/2018, documentation was confirmed to be found by administrator in GH binder on 9/13/20108 to show emergency preparedness drills were conducted. Disaster Hurricane shelter in place conducted on S/25-26/20187; Disaster Evacuation for flood on 6/29/2017; Fire disaster evacuation conducted on 12-27-2017. Copies of documents sent via email to surveyor. 2. The facility conducts semi annual emergency/disaster drills for all shifts each year. 3. Post drills, documentation is placed in fire/emergency binder of facility. Facility was compliant on date of survey Jan 19 2018. 4. Administrator will ensure that disaster evacuations andshelter in place drills are conducted annually.	

AND PLAN OF CORRECTION STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10AL011	A. BUILDING: _____ B. WING	01/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN HOUSE AT EDENTON	584 GENESIS LANE FREDERICK, MD 21703

(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
E4910	Continued From page 9 revealed that the Assisted Living Manager complete the facility's emergency disaster drill. The maintenance man was not able to provide the 2017 evacuation drills from the disaster drill book that was provided.	E4910		

STATE OF MARYLAND
DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY

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

License No. 10al011-K

Issued to: Closup I, Inc.
Garden House At Edenton
5849 Genesis Lane
Frederick, **MD** 21703-5117

Type of Facility: Assisted Living

Level of Care : 3

Number of Beds: 15

Date Issued: July 1, 2018 Non-Expiring

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 un der. This document is not transferable.

Patricia Tomasko May MD

Executive Director

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

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

Fonn AppnNoo4/4/13
DHMH Form ALAPP.1.1

ASSISTED LIVING
APPLICATION FOR UCENSURE

1. GENERAL INFORMATION

CHECK TYPE OF APPLICATION

0 Initial | Iii Renewal | 0 Change of Ownership {specify effective date) | D Other Change {specify type)

LICENSE NUMBER (if appficable) 10AL011-1	IJVEBSITE Qf applicable) www.edenton-retirement.com
LEGAL AGENCY NAME Closup I, Inc	TRADING NAME (OBA) Garden House at Edenton
E-MAIL ADDRESS rbutler@edenton-retirement.com	PHONE NUMBER 3016943100 FAXNUMBER **3016940745**
BUSINESS ADDRESS (physical location)	MAIUNG ADDRESS (if different}
NUMBER, STREET 5849 Genesis Lane	NUMBER, STREET 5800 Genesis Lane
CITY Frederick STATE MD ZIP 21703	CITY Frederick STATE **MD** ZIP 21703

Does the owner, corporation, or partnership operate and manage the assisted living program? 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
15	15	01 02 **lil3**

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

NAME OF MANAGER RaeAnn E. Butler	PHONE NUMBER **(301) 694-3100**	CELL NUMBER **(301) 606-6898**
HOME ADDRESS (nurber, street) 9052 Brookhaven Court	CITY Frederick	STATE MD ZIP 21701
NAME OF ALTERNATE MANAGER **Sandra Stevens**	PHONE NUMBER **3016943100**	CELL NUMBER **3017301464**
HOME ADDRESS (number, street) 4 Park View	*CITY* Boonsboro	STATE MD ZIP 21713
NAME OF DELEGATING NURSE (ON) **Sandra Stevens**	PHONE NUMBER (301) **694-3100**	CEIINUMBER (301) **730-1464**
HOME ADDRESS (nurber, street) 4 Park View	CITY Boonsboro	STATE MD ZIP 21713
DN'S LICENSE NUMBER **R069367**	EXPIRATION DATE OF □N'SLICENSE **09-28-2016**	

Is your facilityplanning to operate, or current!yoperating, an "Alzheimer's Special Care Unit or Program?" LJ No
Iii 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.

FEEATTACHED? Iii Yes

ECEl'v'ED
MAY I 1 206

ECEIVED
MAY 1 1 2016

DHMH Fonn ALAPP.1.1(4113)

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:· •:: Quality

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

SOLE PROPRIETORSHIP PARTNERSHIP CORPORATION

NAME ADDRESS

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

NAME AND TITLE	E-MAIL	PHONE NUMBER	ADDRESS	% OWNED
See attached				

IF CORPORATION:
DATE OF CHARTER 06/17/1986
DATE OF INCORPORATION 06/17/1986
FEIN NUMBER [redacted]

NAME OF PRESIDENT	PHONE NUMBER	CELL NUMBER
RaeAnn E. Butler	(301) 694-3100	(301) 606-6898

ADDRESS (number, street)	CITY	STATE	ZIP
5800 Genesis Lane	Frederick	MD	21703

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? Iii No D Yes (explain)

2. Does the applicant currenUy hold, or has the applicant previously held, any license or certification for the operation of a health care facility or similar health care *program?* 0 No Yes {explain)
Own and operate 4 asssited living facilities on the same campus and a RSA

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

5. WORKERS' COMPENSATION

Do you have any employees? Iii Yes D No
If you answered YES, provide your workers' compensation insurance information:

POLICY NUMBER	BINDER NUMBER	
2014007393366		
INSURANCE COMPANY	EFFECTIVE DATE	EXPIRATION DATE
PMA Insurance CO.	7/1/2014	7/1/2015

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 Pr.ograms 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.

Ifthe program is going ta be in more than one applicant's name, each applicant's signature is required.

SIGNATURE OF APPLICANT	TITLE	DATE
[signature]	Administratr / President	5/6/15
SIGNATURE OF APPLICANT	TITLE	DATE
SIGNATURE Of APPLICANT	TITLE	DATE
SIGNATURE Of APPLICANT	TITLE	DATE

FOR OFFICE USE ONLY

CENSE NUMBER	FEE	CHECK/MO #	CHECK/MO DATE
10AL011-I	$ 600.00	12862	05/05/2015

I

STATE OF MARYLAND
Department of Assessments and Taxation

I, PAUL 8. ANDERSON OF THE STATE DEPARTMENT OF ASSESSMENTS AND TAXATION OF TIIE STATE OF MARYLAND, DO HEREBY CERTIFY THAT THE DEPARTMENT, BY LAWS OF THE STATE, IS THE CUSTODIAN OF THE RECORDS OF THIS STATE RELATING TO THE FORFEITURE OR SUSPENSION OF CORPORATIONS, OR THE RIGHTS OF CORPORATIONS TO TRANSACT BUSINESS IN THIS STATE, AND THAT I AM THE PROPER OFFICER TO EXECUTE THIS CERTIFICATE.

I FURTHER CERTIFY THAT CLOSUP I, INC ., INCORPORATED JUNE 17, 1986, IS A CORPORATION DULY INCORPORATED AND EXISTING UNDER AND BY VIRTUE OF THE LAWS OF MARYLAND AND THE CORPORATION HAS FILED ALL ANNUAL REPORTS REQUIRED, HAS NO OUTSTANDING LATE FILING PENALTIES ON THOSE REPORTS, AND HAS A RESIDENT AGENT. THEREFORE, THE CORPORATION IS AT THE TIME OF THIS CERTIFICATE IN GOOD STANDING WITH THIS DEPARTMENT AND DULY AUTHORIZED TO EXERCISE ALL THE POWERS RECITED IN ITS CHARTER OR CERTIFICATE OF INCORPORATION, AND TO TRANSACT BUSINESS IN MARYLAND.

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

Paul B. Anderson

Paul B. Anderson
Charter Division

301 West Preston Street, Baltimore, Maryland 2120 I
Telephone Balta. Metro (410) 767-1340/Outside Balta. Metro (888) 246-5941
MRS (Maryland Relay Service) (800) 735-2258 TT/Voice
Fax (410) 333-7097

crblnk

R9500005

Closup 1,. nc. d..b.a. Edenton Retirement Community

5800 Genesis Lane Frederick_. MD 21703
Phone 301-694-3100 Fax 301-694-0745

Licenses Issued Include:

Blossom Place at Edenton
Garden House at Edenton
Fiddler's Green af1:denton
Orchard Terrace at Edenton
Home Care Services by Edenton

Stocknolders:

Thomas Callahan II	1731Crestwood Drive NW Washington DCZOOll	50%
Bare Upchurch	P. 0. Box 248 Wye Mills., MD 21679	16.67%
JUI Upchurch	40 T-om Atphin Road l-ex1ngton VA	1-6.-67%
Jack Upchurch Jr	P. 0. Box 328 Wye Mills, MD 21679	16.67%

Board Of Directors;
RaeAnn Butler., President and Secretary
Jack Upchurch Jr., Vice Presi.dent
Thomas Callahan H, Treasurer

TJR.UC-1 OP ID: OT

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DDIYYYY) 06/24/2014

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY 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(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the pollcy(les) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Hamilton Insurance Agency
41:::an .! 7' 11r.r.:::1ri , l'r!
4100 Monument Corner Dr. #500
Fairfax, VA 22030

CT Louise Bell
r: g NJ o. Ext\: 703-359 8100 [r.o?c. No!: 703-359-8108
t, SS: lbell@hamiltoninsurance.com

INSURERISI AFFORDING COVERAGE	NAIC#
INSURER A : Columbia Casually Co.	
INSURER B ; PMA Insurance Company	
INSURER C ; Continental Insurance Company	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED
T.J. Rock Enterprises, Inc.
5800 Genesis Lane
Frederick, MD 21701

COVERAGES CERTIFICATE NUMBER· REVISION **NUMBER·**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS [illegible] EXCLUSIONS AND CONDITIONS OF SUCH POLICIES LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE ☐ OCCUR X Professional LI&D Ded.$0 GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY ☐ PRO-JECT ☐ LOC			4022536113 ETRO DATE 7/1/02	07/01/2014	07/01/2015	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG EmpBen.	$ 1,000,000 $ 100,000 $ 5,001 $ 1,000,000 $ 3,000,000 $ 3,000,000 $ INCLUDED
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS X SCHEDULED AUTOS X HIRED AUTOS X NON-OWNED AUTOS			[illegible]	[illegible]	[illegible]	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (PER ACCIDENT) comp/coll	$ 1,000,000 $ $ $ $ 2,000/2,00[illegible]
A	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $			4022536094	07/01/2014	07/01/2015	EACH OCCURRENCE AGGREGATE	$ 5,000,000 $ 5,000 00[illegible]
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory In NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		2014007393366	07/01/2014	07/01/2015	X WC STATUTORY LIMITS / OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 500,000 $ 500,000 $ 500,00[illegible]

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, If more apace Is required)
Certificate holder is listed as Additional Insured regarding the addition of Orchard Terrace 5905 Edenton Ct., Frederick, MD 21703 ATIM1\..

CERTIFICATE HOLDER

PNC **Bank,** National Assocatlon
Its Successors &/or Assigns
110 Thomas Johnson Dr, Ste 100
Frederick, MD 20217

CANCELLATION

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

AUTHORIZED REPRESENTATIVE
Keith Farnell

Named Insureds per the following:

TJ Rock Enterprises, Inc.

Potomac Valley Nursing Facilities, Inc. d/b/a Potomac Valley Nursing and Wellness Center
1235 Potomac Valley Road
Rockville, MD 20850

Collingswood Nursing Facilities, Inc. d/b/a Collingswood Nursing and habilitation Center
Rockville MD 20850

Upchurch Family Limited Partnership
1T&LC&98TLC2, LP
Upchurch Purchase, LLC
JA Upchurch Sr. Revocable Stock

Named Insureds per the following:

Closup I, Inc.
Closup I, Inc. d/b/a Edenton Retirement Community
Closup I, Inc. d/b/a The Garden House at Eilenton
Closup I, Inc. d/b/a Blossom Place at Edenton
Closup I, Inc. d/b/a Orchard Terrace
Closup I, Inc. d/b/a Orchard Terrace
denton Retirement Community Home Care Services
Edenton Frederick, LLC
TJ Rock Enterprises, Inc. 401(k) Plan

EDEN TON

Independent Living • Assisted Living • Dementia Care

May 4, 2015

Assisted Living Unit
D.H.M.H.
Office of Health Care Quality
Bland Bryant Building - Spring Grove Center
55 Wade Avenue
Catonsville, MD 21228

RE: Assisted Living Renewals

To Wnom it May Concem;

Enclosed please find the renewal applications for the following assisted living licenses at Edenton Retirement Community -

Garden House at Edenton	License #IOALOl 1-I
Fiddlers Green at Edenton	License #10Al02 l -I
Blossom Place at Edenton	License# 10Al020-I

In addition to the application pages, enclosed are separate checks for each renewal application.

Please do not hesitate to contact me should you have any questions regarding the application renewals for the facilities at Edenton Retirement Community.

Sincerely,

11t.;;;:

Administrator

Encl.

RECEIVED
M Y \ \ 20b
Office of
Health Care Quality

5800 Genesis Lane • Frederick, Maryland 21703
301-694-3100 • 301-831-1300 • FAX 301-694-0745 • www.edenton-retirement.com

State of Maryland
Department of Health and Mental Hygiene

2015-0097

Frederick County, Maryland
Environmental Health Services

This License has been granted to:

Closup **1,** Inc. d.b.a. Edenton Retirement Community

to operate a food service facility trading as:

Garden House at Edenton
5849 Genesis Lane
Frederick, MD 21703

THIS LICENSE IS GRANTED PURSUANT TO THE ANNOTATED CODE OF MARYLAND, HEALTH GENERAL ARTICLE 21-305 AND IS SUBJECT TO ANY AND ALL STATUTORY PROVISIONS INCLUDING ALL APPLICABLE RULES AND REGULATIONS PROMULGATED THEREUNDER.

License Number: 4443
Date Issued: 01/07/2015
Expiration Date: 01/31/2016

Barbara A. Brookmyer, M.D., M.P.H.
Health Officer, Frederick County

(NOT TRANSFERABLE EXCEPT AS EXPRESSLY PROVIDED BY RULE OR REGULATION)

POST IN CONSPICUOUS PLACE FOR PUBLIC VIEW

Frederick County Fire/kescue Services
Office of the County Fire Marshal
5370 Public Safety Place
Frederick, MD 21704-6677

Contact information
Office: 301-600-1479
Facsimile: 301-600-2592
Website: www.co.frederick.rnd.u s/FM

NOTICE OF VIOLATION/ABATEMENT OlU)ER

RAEANN BUTLER
5800 GENESIS LANE
FREDE RICK, MD 21703

Case Number : **CASE8586**

CASE8586

RE: GARDEN HOUSE AT EDENTON
5800 GENESIS LN
FREDERICK,MD 21703-

An inspection was conducted at the occupancy referenced above on **4/9/2015.** Any Fire Prevention Code violations that were noted and corrected at the time of the inspection are noted below. This inspection has been **RESOLVED/PASSED** and no further action is requ i red.

I **attest to the fact that the statements made in this report are correct and accurate to the best of my knowledge.**
Issued By: Charles Green, Fire Marshal Email : cgreen@frederickcountymd.gov

I **n.-knowledge receipt of the Notice of Violation/Abatement Order.**

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
	10AL011	A. BUILDING: _____ B. WING _____	C 04/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN HOUSE AT EDENTON	5849 GENESIS LANE FREDERICK, MD 21703

(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 April 26, 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 Assisted Living Manager. The facility's census at the time of the survey was 25 residents. Based on survey findings, in relation only to complaint # MD00111556, the facility was found to be in compliance with COMAR 10.07.14, the regulations governing assisted living programs.	E 000		

OHCQ

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

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
	10AL011	A. BUILDING: _____ B. WING _____	C 10/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN HOUSE AT EDENTON	5849 GENESIS LANE FREDERICK, MD 21703

(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 October 24, 2017, 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 Executive Director. The facility's census at the time of the survey was 13 residents. Based on survey findings, in relation to intake# MD00118586, the facility was found to be in compliance with COMAR 10.07.14, the regulations governing assisted living programs.	E 000		

OHCQ

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