STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	12/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlotte Hall Veterans Home	29449 Charlotte Hall Road Charlotte Hall, MD 20622

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation, medical record review and resident and staff interviews it was determined the facility failed to ensure that a call light button was within reach for residents capable of using them. This was evident for 1 (Resident #165) out of 8 selected for review during the survey. The findings include: Resident #165 is in end stage condition on hospice services. According to the care plan he/she will potentially decline in physical function level, however Resident #165 still could use his/her call light to alert staff of needs. On 11/28/18 at 09:57 A.M. during Resident #165's interview, the surveyor observed that the resident's call light button was out of reach and was hanging in a downward position on the bed side rail. It was knotted in place out of the resident's reach. The resident asked the surveyor to press the call light for help. The surveyor asked Resident #165 how long his/her call light had been out of reach. Resident #165 replied, that they always put it where I can't find it, so, I call out for help. On 11/28/18 at 10:05 A.M. the Geriatric Nursing Assistant (GNA staff #11) was observed rearranging the call light button for Resident #165 and placed it within the resident's reach. On 11/28/18 at 10:10 A.M. during an interview with staff member #8, the surveyor was informed that Resident #165 is capable and independently uses his/her call light button for any assistance. On 12/04/18 at 1:59 P.M. during a second observation a family member was visiting with Resident #165 and the surveyor observed that the call light button was located under the resident's bed. The Family member replied, that call bell button is always on the floor when I visit and I place it on the bed. On 12/4/18 at 2:10 P.M. staff member #8 verified that Resident #165's call light button was under the resident's bed and observed staff member #8 repositioning the call light within Resident #165's reach. On 12/4/18 at 2:20 PM during an interview with staff member #7 (Unit Manager) it was stated that all resident's call light buttons are always to be within the residents reach. The Administrator and Director of Nursing was informed of the concerns prior and during the survey exit.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and medical record review it was determined the facility staff failed to implement care plan interventions to ensure that residents' fall safety devices were operational. This was evident for 3 of 3 sampled residents (R#1, R#9 and R#10) reviewed for safety devices. The findings include: 1. On 2/28/19 at 3:20 PM, Resident #1 was observed sitting in a wheelchair close to the nurses' station. A wheelchair pad sensor was underneath the resident and the pad was attached by a cord to a monitor on the back of the chair which was to sound an alarm if the resident stood up. Two surveyors looked at the alarm and were unable to tell if it was on or off. Geriatric Nursing Assistant (GNA) #1 was asked how to tell if the alarm was on or off. GNA #1 rolled back the soft cover next to the switch to reveal small print that indicated when the switch was on or off. In doing so, it revealed that the alarm was off. The GNA then switched the alarm back on. On 2/28/19 during medical record review, it was noted that the resident had a physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . The resident was, also, found to have a care plan for being at risk for injury/falls. One of the interventions listed in the care plan was for the use of a wheelchair pad alarm. 2. Medical record review on 2/28/19 revealed that Resident #9 has a care plan which was developed on 12/1/16 due to the resident's risk for falls with injury secondary to impaired mobility and a history of falls. A care plan intervention was added on 1/4/19 for a wheelchair cushion alarm when out of bed. On 2/28/19 between 2:30 P.M. and 2:45 P.M. Resident #9 was observed in his/her room in the wheelchair. The resident had a wheelchair cushion alarm, however, the alarm was observed in the off position. A facility staff member was with the surveyor when the observation was made and the wheelchair cushion alarm was turned on at that time. 3. Medical record review on 2/28/19 revealed that Resident #10 has a care plan which was developed on 2/16/18 due to the resident's risk for falls due to impaired mobility and a history of falls. A care plan intervention was added on 3/7/18 for a wheelchair cushion alarm. On 2/28/19 between 2:30 P.M. and 2:45 P.M. Resident #10 was observed in his/her room in the wheelchair. The resident had a wheelchair cushion alarm, however, the alarm was observed in the off position. A facility staff member was with the surveyor when the observation was made and the wheelchair cushion alarm was turned on at that time.

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F 0657 Level of Harm - Actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview of facility staff it was determined the facility staff failed to ensure that care plan interventions were implemented: 1) the facility failed to intervene and revise Resident #175's care plan related to tobacco use. This failure occurred when Resident #175 showed signs of decline in cognitive status and activities of daily living, indicating that the resident was not safe to smoke without supervision. It was determined that the facility's failure to revise Resident #175's care plan interventions resulted in an actual harm to the resident from a smoking related accident with injury, and 2) the facility failed to revise and update the care plan that addressed Resident #51's care after a change in condition. This was evident for 2 out of 12 residents reviewed during the survey process. The findings include: 1) Resident #175's medical record was reviewed on 11/30/18. Medical record review revealed that Resident #175 has resided at the facility since February 2018. The resident has diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Medical record review revealed that on 2/16/18 a smoking screen was completed by the Certified Dementia Practitioner, Staff #11, who determined that the resident was safe to smoke unsupervised. Medical record review revealed that on 2/16/18 the facility staff initiated a care plan related to Resident #175's tobacco use on a regular basis with the goal that the resident would be safe and free of injury. Interventions initiated on 2/16/18 included: Inform resident of appropriate smoking areas and redirect as needed; encourage residents not to have lighters, cigarettes or other smoking materials in their room; encourage resident to smoke with staff and/or family present; place smoking apron on resident following ADL (activities of daily living) if needed; assess for safety per policy; notify Administration of non-compliance. Review of Resident #175's Minimum Data Set (MDS), an assessment tool, dated 2/22/18 revealed that the resident required supervision with the assistance of 1 staff member for eating. The resident had no functional range of motion impairment according to the MDS. Medical record review revealed that on 7/5/18 at 10:25 P.M. the nurse documented in the progress notes that the resident was reported to be in the basement attempting to smoke a cigarette. The nurse further documented that the resident was alert and oriented x 3 (to person, place and time) upon return to the unit. The resident stated that he/she was aware that he/she was in the basement. Medical record review revealed that on 7/6/18 at 11:10 A.M. the nurse documented that burn holes were noted on the resident's shorts. The cushion next to his/her right leg had burn holes from cigarettes. Next to the resident's leg a cigarette had burned and was stuck to the cushion. The nurse further documented that a smoking apron was ordered for the resident to use at all times. The care plan was revised at that time and an intervention was added to place a smoking apron on the resident prior to smoking. Also, on 7/6/18 a physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Some	Medical record review revealed that on 7/10/18 at 3:40 P.M. the nurse documented that a medication review was completed due to a significant change noted to the resident's condition secondary to cognitive status and mobility decline. Medical record review revealed that on 7/11/18 the resident was certified by the attending physician that he/she was unable to understand the nature, extent, or probable consequences of the proposed treatment or course of treatment and is unable to make a rational evaluation of the burdens, risks, and benefits of treatment. On 7/19/18, a second physician concurred with the attending physician's certification of 7/11/18. Medical record review revealed that on 7/14/18 at 1:43 P.M. the nurse documented that the resident is unsteady smoking by himself/herself, and that cigarettes were found still lit in the resident's chair. On 7/14/18 at 11:56 P.M. the nurse documented that the resident was found by the Geriatric Nursing Assistant (GNA) and the nurse in the basement. Medical record review revealed that on 7/22/18 at 3:46 P.M. the nurse documented that the resident was found in bed with scissors and pieces of his/her smoking apron. The resident stated he/she was trying to get the smoking apron off. Medical record review revealed that on 7/23/18 at 6:00 A.M. and 2:00 P.M. the nurse documented in the Treatment Administration Record (TAR) that the resident did not wear a smoking apron. There was no documentation in the medical record to indicate the reason the resident did not wear a smoking apron on those dates. Medical record review revealed that on 7/24/18 at 6:00 A.M. and 2:00 P.M. the nurse documented in the TAR that the resident did wear a smoking apron. However, on 7/24/18 at 7:32 P.M. the nurse documented that the resident's smoking apron was unavailable, and the resident was outdoors to smoke with staff assistance. Medical record review revealed that on 9/15/18 at 10:44 P.M. the nurse documented that the resident was noted with dry cigarette [CONDITION(S)] to the left upper thigh. The physician and responsible party were notified. The physician gave no new orders. The responsible party stated that he/she would like to bring a caretaker for the resident to assist him/her during the day by taking him/her outside to smoke and to ensure that he/she is getting his/her meals. Medical record review revealed that on 9/22/18 at 3:41 P.M. the nurse documented in the medical record that the resident was propelling self on and off the unit, was very confused and non-compliant and was found on the third floor hitting and banging on a locked door. The nurse further documented that the resident was unable to hold his/her cups without spilling the fluid and was found outside in the rain just sitting there. The resident had to be redirected most of the day and was unable to follow a direction such as can you take your arm out of your jacket. Medical record review revealed that on 9/23/18 at 10:02 P.M. the nurse documented that the resident was out of bed to smoke cigarettes in the courtyard with assistance from the nursing staff and ate 75% of dinner with assistance because his/her hands were shaking and could not hold a spoon. Medical record review revealed that on 9/25/18 at 4:11 P.M. the nurse documented that the resident had to be redirected several times during the day and was not sure where he/she was going. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Some	Medical record review revealed that on 9/27/18 at 3:59 P.M. the nurse documented that the resident was assisted to smoke in the court yard by nursing staff. Medical record review revealed that between 9/27/18 through 10/19/18 there was no documentation in the nursing progress notes that the resident was assisted with smoking. Review of the October 2018 TAR revealed that staff documented that the resident did not use a smoking apron on 10/1/18 at 2:00 P.M., 10/4/18 at 10:00 P.M., and 10/6/18 at 6:00 A.M., 2:00 P.M. and 10:00 P.M. There was no documentation in the medical record to indicate the reason the resident did not wear a smoking apron on those dates. Review of Resident #175's Minimum Data Set (MDS) dated [DATE] revealed that the resident required extensive assistance of 1 staff member for eating. That represented a decline in the resident's ability to eat compared to the MDS dated [DATE] in which it was documented that the resident required supervision with the assistance of 1 staff member for eating. Additionally, the MDS dated [DATE] reflected that the resident had a functional range of motion impairment to 1 side of both the upper and lower extremities. Medical record review revealed that on 10/17/18 a smoking screen was completed by the Certified Dementia Practitioner, Staff #11, and it was determined that the resident was safe to smoke despite documented evidence on 7/5/18 through 9/27/18 that the resident exhibited indicators that he/she was not safe to smoke unsupervised. Interview of Staff #11 on 11/30/18 at 2:00 P.M. revealed that nursing had never reported a concern regarding the resident's cognitive and physical decline or other indicators that the resident may not be safe to smoke unsupervised. Staff #11 further stated that she became aware that the resident required a smoking apron when the resident asked for one at the nurses station, and prior to 7/9/18, she had not observed the resident with a smoking apron. Although Resident #175 had experienced a decline in his/her physical and cognitive abilities, as evidenced by the aforementioned incidents, the facility staff failed to revise the resident's care plan after 10/14/18 to ensure that safeguards were in place to guarantee that the resident was compliant with safe smoking interventions. Medical record review revealed that on 10/20/18 at 6:00 A.M. the nurse documented in the TAR that the resident used the smoking apron. Medical record review revealed that on 10/20/18 at 10:38 A.M. the nurse documented the following entry in the progress notes: Resident is alert and oriented with moments of confusion but [verbally] able to make needs known. Multiple nurses reported to this nurse [writer] that the [patient] was outside in the courtyard smoking a cigarette and [his/her] clothing caught on fire at 9:30 A.M. Activities aid attempted to put the fire out by patting with her hands, but a nurse arrived with blanket/towel and put the fire out. The patient was then [transferred] in [his/her] wheelchair from the courtyard to [his/her] room and [transferred] to bed for first aid (clothes cut off and cold towels applied) and skin assessment completed: [CONDITION(S)]/discolorations noted to Left thigh, left abdomen, left wrist, left inner elbow, left chest, bilateral sides of neck and back of [his/her] neck. [Nurse practitioner] notified new order to send out via 911. [Responsible party] notified and made aware that patient will be going to [name of hospital] via helicopter . The resident was subsequently admitted to the hospital and treated for [MEDICAL RECORD OR PHYSICIAN ORDER] . (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Some	Interview of the Director of Nursing on 11/30/18 at 1:30 P.M. revealed that charge nurses are responsible for implementing care plan interventions related to smoking safety. The resident was not wearing a smoking apron when the resident's clothing caught fire on 10/20/18. The smoking apron was found in the resident's room. On 10/20/18, the resident had been given cigarettes which were kept at the nurses' station. Further interview of the DON revealed that the resident went outside to smoke multiple times a day. As of 10/20/18, there was no supervision once residents went outside to the facility courtyard to smoke. The courtyard was open for residents to smoke 24 hours a day, 7 days a week. 2) The care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. Medical record review revealed that Resident #51 was admitted to the facility with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Alzheimer's disease (AD) is a common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities. People with AD may have trouble remembering what happened recently or names of people they know. The surveyor reviewed of facility reported incident on 11/29/18, it revealed that on 09/25/18 and 10/27/18 Resident #51 had experienced falls. Medical record review revealed a fall care plan with an admission initiation dated 03/06/2018 which included goals and approach interventions for fall prevention. Further review of the medical record revealed that the facility failed to update and revise the care plan that addressed the resident's falls which occurred on 09/25/18 and 10/17/18. On 11/30/18 at 11:30 A.M. during an interview with staff member #6 and the Director of Nursing, it was verified that facility staff did not revise Resident #51's fall care plan after reported falls that occurred on 09/25/18 and 10/17/18. The Administrator, Director of Nursing with Corporate Representatives were informed of the concerns prior and during the survey exit.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview of facility staff it was determined the facility staff failed to keep Resident #175 safe from injury by failing to intervene and ensure that Resident #175 was supervised when smoking and when Resident #175 showed a decline in cognitive status in activities of daily living. This was evident for 1 out of 7 residents reviewed for hospitalization and 1 out of 12 residents reviewed for accidents. It was determined that the facility's failure to ensure that Resident #175 was safe to smoke without supervision resulted in past non-compliance immediate jeopardy which existed from 7/5/18 through 10/20/18. The Nursing Home Administrator was notified on 11/30/18 at 4:30 P.M. The findings include: Resident #175's medical record was reviewed on 11/30/18. Medical record review revealed that Resident #175 has resided at the facility since February 2018. The resident has diagnoses that include [MEDICATION(S)] dependence and a history of a [CONDITION(S)] resulting in left sided weakness. Medical record review revealed that on 2/16/18 a smoking screen was completed by the Certified Dementia Practitioner, Staff #11, who determined that the resident was safe to smoke unsupervised. Medical record review revealed that on 2/16/18 the facility staff initiated a care plan related to Resident #175's tobacco use on a regular basis with the goal that the resident would be safe and free of injury. Interventions initiated on 2/16/18 included: Inform resident of appropriate smoking areas and redirect as needed; encourage residents not to have lighters, cigarettes or other smoking materials in their room; encourage resident to smoke with staff and/or family present; place smoking apron on resident following ADL (activities of daily living) if needed; assess for safety per policy; notify Administration of non-compliance. Review of Resident #175's Minimum Data Set (MDS), an assessment tool, dated 2/22/18, revealed that the resident required supervision with the assistance of 1 staff member for eating. Medical record review revealed that on 7/5/18 at 10:25 P.M. the nurse documented in the progress notes that the resident was reported to be in the basement attempting to smoke a cigarette. The nurse further documented that the resident was alert and oriented x 3 (to person, place and time) upon return to the unit. The resident stated that he/she was aware that he/she was in the basement. Medical record review revealed that on 7/6/18 at 11:10 A.M. the nurse documented that burn holes were noted on the resident's shorts. The cushion next to his/her right leg had burn holes from cigarettes. Next to the resident's leg a cigarette had burned and was stuck to the cushion. The nurse further documented that a smoking apron was ordered for the resident to use at all times. The care plan was revised at that time and an intervention was added to place a smoking apron on the resident prior to smoking. Also, on 7/6/18 a physician's order was entered for the resident to use a smoking apron at all times when out to smoke. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Smoking Safe Policy revealed smoking assessments are completed by social services staff on all residents upon admission, quarterly and with significant changes in the residents' medical, physical, or mental condition. This would, also, include any unsafe practice or smoking incident. If interventions are necessary based on the assessment, or a smoking incident, a care plan will be developed by the interdisciplinary team. If safety equipment is required (related to an isolated event, i.e., smoking apron), a nursing order will be written and the equipment entered on the treatment record; the nurse will document compliance or non-compliance to use of the equipment on a daily basis on the treatment record. Additional information provided by the facility on 12/11/18 revealed that on the treatment record a check indicates compliance and N indicates apron was not in use due to resident being out of facility, not smoking or being non-compliant with wearing the smoking apron. Medical record review revealed that on 7/10/18 at 3:40 P.M. the nurse documented that a medication review was completed due to a significant change noted to the resident's condition secondary to cognitive status and mobility decline. Medical record review revealed that on 7/11/18 the resident was certified by the attending physician that he/she is unable to understand the nature, extent, or probable consequences of the proposed treatment or course of treatment and is unable to make a rational evaluation of the burdens, risks, and benefits of treatment. On 7/19/18, a second physician concurred with the attending physician's certification of 7/11/18. Medical record review revealed that on 7/14/18 at 1:43 P.M. the nurse documented that the resident is unsteady smoking by himself/herself, and cigarettes were found still lit in the resident's chair. On 7/14/18 at 11:56 P.M. the nurse documented that the resident was found by the Geriatric Nursing Assistant and the nurse in the basement. Medical record review revealed that on 7/22/18 at 3:46 P.M. the nurse documented that the resident was found in bed with scissors and pieces of his/her smoking apron. The resident stated he/she was trying to get the smoking apron off. Medical record review revealed that on 7/23/18 at 6:00 A.M. and 2:00 P.M. the nurse documented in the Treatment Administration Record (TAR) that the resident did not wear a smoking apron. There is no documentation in the medical record to indicate the reason the resident did not wear a smoking apron on those dates. Medical record review revealed that on 7/24/18 at 6:00 A.M. and 2:00 P.M. the nurse documented in the TAR that the resident did wear a smoking apron. However, on 7/24/18 at 7:32 P.M. the nurse documented that the resident's smoking apron was unavailable and the resident was out to smoke with staff assistance. Medical record review revealed that on 8/6/18 at 2:34 P.M. the nurse documented that the resident was out of bed in the wheelchair to smoke cigarettes in the court yard at that time. On 8/16/18 at 11:10 P.M., 8/18/18 at 8:52 P.M. and 8/22/18 at 10:52 P.M. the nurse documented that the resident was out of bed in the wheelchair propelling himself/herself in and out of the courtyard to smoke. On 9/7/18 at 9:48 P.M. the nurse documented that the resident was out of bed in the wheelchair to smoke cigarettes in the courtyard. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Medical record review revealed that on 9/15/18 at 10:44 P.M. the nurse documented that the resident was noted with dry cigarette [CONDITION(S)] to the left upper thigh. The physician and responsible party were notified. The physician gave no new orders. The responsible party stated that he/she would like to bring a caretaker for the resident to assist him/her during the day by taking him/her outside to smoke and to ensure that he/she is getting his/her meals. Medical record review revealed that on 9/22/18 at 3:41 P.M. the nurse documented in the medical record that the resident was propelling self on and off the unit, was very confused and non-compliant and was found on the third floor hitting and banging on a locked door. The nurse further documented that the resident was unable to hold his/her cups without spilling the fluid and was found outside in the rain just sitting there. The resident had to be redirected most of the day and was unable to follow a command such as can you take your arm out of your jacket. Medical record review revealed that on 9/23/18 at 10:02 P.M. the nurse documented that the resident was out of bed to smoke cigarettes in the courtyard with assistance from the nursing staff and ate 75% of dinner with assistance because his/her hands were shaking and could not hold a spoon. Medical record review revealed that on 9/25/18 at 4:11 P.M. the nurse documented that the resident had to be redirected several times during the day and was not sure where he/she was going. Medical record review revealed that on 9/27/18 at 3:59 P.M. the nurse documented that the resident was assisted to smoke in the courtyard by nursing staff. Medical record review revealed that between 9/27/18 through 10/19/18 there is no documentation in the nursing progress notes that the resident was assisted with smoking. Review of the October 2018 TAR revealed that staff documented that the resident did not use a smoking apron on 10/1/18 at 2:00 P.M., 10/4/18 at 10:00 P.M., and 10/6/18 at 6:00 A.M., 2:00 P.M. and 10:00 P.Mm. There is no documentation in the medical record to indicate the reason the resident did not wear a smoking apron on those dates. Review of Resident #175's Minimum Data Set (MDS) dated [DATE] revealed that the resident required extensive assistance of 1 staff member for eating. This represents a decline in the resident's ability to eat compared to the MDS dated [DATE] in which it is documented the resident required supervision with the assistance of 1 staff member for eating. Although the resident had experienced a decline in his/her ability to eat, the interdisciplinary team failed to reconsider the resident's ability to safely smoke without assistance and/or supervision. Medical record review revealed that on 10/17/18 a smoking screen was completed by the Certified Dementia Practitioner, Staff #11, and it was determined that the resident was safe to smoke. Interview of Staff #11 on 11/30/18 at 2:00 P.M. revealed that nursing had never reported a concern regarding the resident's cognitive and physical decline or other indicators that the resident may not be safe to smoke unsupervised. Staff #11 further stated that she became aware that the resident required a smoking apron when the resident asked for one at the nurses' station, and prior to 7/9/18, she had not observed the resident with a smoking apron. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	12/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlotte Hall Veterans Home	29449 Charlotte Hall Road Charlotte Hall, MD 20622

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Although Resident #175 had experienced a decline in his/her physical and cognitive abilities, as evidenced by the aforementioned incidents, the facility staff failed to revise the resident's care plan after 10/14/18 to ensure that safeguards were in place to guarantee the resident was compliant with safe smoking interventions. Medical record review revealed that on 10/20/18 at 6:00 A.M. the nurse documented in the TAR that the resident used the smoking apron. Medical record review revealed that on 10/20/18 at 10:38 A.M. the nurse documented the following entry in the progress notes: Resident is alert and oriented with moments of confusion but [verbally] able to make needs known. Multiple nurses reported to this nurse [writer] that the [patient] was outside in the courtyard smoking a cigarette and [his/her] clothing caught on fire at 9:30 A.M. Activities aid attempted to put the fire out by patting with her hands, but a nurse arrived with blanket/towel and put the fire out. The patient was then [transferred] in [his/her] wheelchair from the courtyard to [his/her] room and [transferred] to bed for first aid (clothes cut off and cold towels applied) and skin assessment completed: [CONDITION(S)]/discolorations noted to Left thigh, left abdomen, left wrist, left inner elbow, left chest, bilateral sides of neck and back of [his/her] neck. [Nurse practitioner] notified new order to sent out via 911. [Responsible party] notified and made aware that patient will be going to [name of hospital] via helicopter . The resident was subsequently admitted to the hospital and treated for [CONDITION(S)] to the anterior neck, left upper extremity and left trunk. Interview of the Director of Nursing (DON) on 11/30/18 at 1:30 P.M. revealed that charge nurses are responsible for implementing care plan interventions related to smoking safety. The resident was not wearing a smoking apron when the resident's clothing caught fire on 10/20/18. The smoking apron was found in the resident's room. On 10/20/18, the resident had been given cigarettes by staff which were kept at the nurses station. Further interview of the DON revealed that the resident went outside to smoke multiple times a day. As of 10/20/18, there was no supervision once residents went outside to the facility courtyard to smoke. The courtyard was open for residents to smoke 24 hours a day, 7 days a week. As a result of the smoking related injury sustained by Resident #175 on 10/20/18, the following Performance Improvement Plan was initiated: 10/20/18: Director of Safety and Security replaced fire blankets and fire extinguisher; smoking monitor initiated; smoking materials secured; dial a call notification sent to families of smoking process changes; Director of Social Services initiated/audited smoking assessment audits - all smoking audits were in place; Director of Nursing met with residents; initiated specific smoking times; Director of Nursing initiated staff in-servicing on new smoking process; Director of Safety and Security initiated in-servicing on new smoking process with security. 10/22/18: Further revisions to designated smoking times; DON met with residents; updated smoking assessments initiated on all smoking residents to ensure they reflected residents' current status; revised smoking monitor guidelines, in-serviced with all guidelines and book provided with picture of all smoking residents; Director of Quality Assurance reached out to ombudsman for guidance with resident rights versus culture change. (continued on next page)

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	215161	A. Building B. Wing	12/04/2018

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10/24/18: Separated assisted living and skilled nursing facility smoking areas; cart put in place for smoking monitor; all residents of skilled nursing facility required to wear smoking apron which was initiated; communication log book added to smoking monitor cart; walkie talkies put in place to improve communication between smoking monitor and supervisors; labeled smoking apron for each resident and added to smoking cart (previously were kept in residents' rooms). 10/25/18: Nursing began participating in smoking assessments; Director of Safety and Security will monitor fire blankets and extinguishers in designated smoking areas and report in quality assurance meetings monthly; Director of Social Services will monitor completion of smoking assessments and report in quality assurance meetings monthly. 10/29/18: Interdisciplinary review of updates to smoking process. 10/31/18: State Ombudsman met with Director of Quality Assurance to review changes implemented to the smoking process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	12/04/2018

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on medical records and staff interview, it was determined that the facility staff failed to establish a plan for Resident #328, related to the resident having a Foley catheter. This was evident for 1 out of 1 resident's investigated for a Foley catheter during the survey process. The findings include: On 11/30/18 at around 09:32 AM, it was noted that Resident #328 had an indwelling Foley catheter (a Foley catheter is a flexible tube which a clinician passes into the bladder to drain urine). On 12/3/18 this surveyor was reviewing Resident #328's medical record. The medical record revealed that the resident had been admitted during the beginning of the year with the Foley catheter in place. Review of the resident's medical record did not reveal any plans for the tapering, continuation or discontinuation of the Foley. Further review reveled that there had not been a Urologist 's follow-up/consult since the resident's admission. On 12/04/18 at 02:44 PM, during a meeting with the Director of Nursing (DON), staff #9, staff #2, staff #10 and the Medical Director it was confirmed that there had not been an urology follow-up/consult related to Resident #328's Foley catheter placement.

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	215161	A. Building B. Wing	12/04/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on inspection of medication storage areas and staff interview it was determined the facility failed to ensure that the pharmacy assured accuracy in the labeling of a medication for Resident #159. The findings include: On [DATE] at 10:40 AM during an inspection of a medication cart on Unit 2 C, a [MEDICATION(S)] discus prescribed for Resident #159 was found with an incorrectly labeled expiration date. A [MEDICATION(S)] discus contains a corticosteroid which, when inhaled, can decrease inflammation and swelling within the airways. On the [MEDICATION(S)] box, the date opened was marked as [DATE] and the expiration date was marked as [DATE]. This is a total of approximately 8 weeks. A note on side of box states: Discard 6 weeks after opening the foil pouch or when the counter reads 0 (after all blisters have been used), whichever comes first. On [DATE] at 10:58 AM, Unit Manager #2, who was present during the finding, stated that the pharmacy writes the date when opened and the date when expired on the labels. When asked how the Pharmacist would know when the medication is opened, she said the medication arrives on the unit like that. During an interview with Pharmacist #4, she confirmed the pharmacy marks medications with the date opened on the date they are dispensed, and the expiration date is then calculated and marked on the box based on the dispensing date. For medications whose expiration date changes after opening, it is standard nursing practice for the nurse to write the date when opened and to calculate the new expiration date based on that date. The date dispensed and the date opened are not always the same date. Cross-reference with F 761.

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	215161	A. Building B. Wing	12/04/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medication storage areas and staff interview, it was determined the facility failed to ensure that medications that expire were labeled appropriately. This was evident for 2 medications found in 2 of the 15 storage areas reviewed during the survey. The findings include: On [DATE] at 11:38 AM during a review of the medication refrigerator on Unit 2 B, an open but undated 3 milliliter multidose vial of [MEDICATION(S)] was found. [MEDICATION(S)] is an influenza vaccine used for flu shots. Per manufacturer's instructions, Once the stopper has been pierced, the vial must be discarded in 28 days. Since the opened vial was not marked with the date when opened, the expiration date was unknown. This was confirmed by staff nurse #3 who was present at the time. On [DATE] at 10:40 AM during an inspection of a medication cart on Unit 2 C, a [MEDICATION(S)] discus prescribed for Resident #159 was found with an incorrectly labeled expiration date. A [MEDICATION(S)] discus contains a corticosteroid which, when inhaled, can decrease inflammation and swelling within the airways. On the [MEDICATION(S)] box, the date when opened was marked as [DATE] and the expiration date was marked as [DATE]. That was a total of approximately 8 weeks. A note on the side of the box stated, Discard 6 weeks after opening the foil pouch or when the counter reads 0 (after all blisters have been used), whichever comes first. On [DATE] at 10:58 AM Unit Manager #2, who was present during the finding, stated that the pharmacy writes the date when the medication is opened and the date expired on the labels. When asked how the Pharmacist would know when the medication is opened, Unit Manager #2 said the medication arrives on the unit like that. Since the pharmacy is located inside the facility, an interview with Pharmacist #4 was conducted. She confirmed the pharmacy marks medications with the date when opened on the date they are dispensed, and the expiration date is then calculated and marked on the box based on the dispensing date. She acknowledged that pharmacy staff had made a mathematical error on this medication when calculating the expiration date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	12/04/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews the facility staff failed to follow through on a physician's laboratory order for Resident #140. This was evident for 1 out of 5 residents investigated for unnecessary meds during the survey process. The findings include: On 11/28/18 while reviewing Resident #140's medical orders for unnecessary medications, it was noted that a physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of the medical record revealed that the bloodwork scheduled for August 2018 had not been done. The Surveyor informed the Unit Manager and Director of Nursing of the findings.

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	215161	A. Building B. Wing	12/04/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview it was determined the facility failed to follow-up on a dental consult for Resident #18. This was evident for 1 of 1 residents reviewed during the survey. The findings include: On 11/27/18 at 10:36 AM during an interview, Resident #18 stated his/her gums hurt at night when his/her dentures are removed. When asked if he/she had told anyone, he/she said yes. When asked what staff said, he/she stated they said they would take care of it. At 1:50 PM during a review of the medical record for Resident #18, a physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . At 1:52 PM, Unit Clerk #1 was asked if the resident had an appointment scheduled with a Dentist. She stated that she did not see a slip for him but a request to schedule might have been sent. When questioned, she stated, a yellow slip is sent to a scheduler when an appointment is needed, but normally it would have been returned within a week stating when the appointment was scheduled. Unit Manager #2 was then interviewed, as well. She confirmed that a dental appointment had not been made prior to surveyor intervention.

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	215161	A. Building B. Wing	02/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlotte Hall Veterans Home	29449 Charlotte Hall Road Charlotte Hall, MD 20622

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical record and interview with facility staff, it was determined that the facility failed to ensure that physicians were notified of and responded to behavioral and cognitive changes in a resident with worsening behaviors. This was evident for 1 (Resident #2) of 7 residents reviewed during the survey. The findings include: In the course of investigating Complaint #MD 333, Resident #2's responsible party (RP) was contacted for interview on 2/20/20 at 12:39 PM. During the interview, the RP stated that Resident #2 demonstrated increased confusion, combativeness, and inappropriate or destructive behaviors in December, 2019. The RP stated these behaviors first became evident after the resident sustained [MEDICAL RECORD OR PHYSICIAN ORDER] . However, the RP noted that the behaviors increased in severity and frequency much more rapidly in December. The RP asserted that the facility failed to satisfactorily address these changes, allowing the resident to worsen without explanation or treatment. Resident #2's medical record was reviewed on 2/21/20 at 9:25 AM. During the review, progress notes from multiple disciplines demonstrated that Resident #2 was experiencing significant confusion and had behaviors that were inappropriate and sometimes destructive in December 2019. On 12/1/19, a progress note documented that the resident pulled a nursing assistant's lanyard (badge holder) on her neck but then the resident had become calm and apologetic. On 12/3/19, a progress note documented that the resident was given [an inhaler] to use and the resident put the wrong end into his/her mouth to administer to self. On 12/4/19, a progress note documented that the resident was screaming or pulling on the call light, unable to express his/her needs. On 12/6/19, a progress note documented that the resident appears to be very confused at this time. On 12/8/19, a progress note documented that the resident was yelling off and on through the night stating 'let me up, let me up.' On 12/12/19, a progress note documented that the resident broke the call light twice by ripping it out of the wall, then denied it. On 12/14/19 , a progress note documented that the resident was calling for maintenance to take him/her home to his/her car. On 12/15/19, a progress note docuemnted that the resident said, I did not murder the girl, and go get my car parts. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	02/24/2020

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although the above progress notes documented episodes of confusion and inappropriate behavior, three notes in particular indicated that the resident's cognition had worsened from baseline. On 12/16/19, a therapist note stated, The therapist talked to the nurse and rehab team about changes in the resident's behavior. He stated that the resident has become more resistive with exercises and increased confusion were observed. On 12/22/19, a therapist note stated, The [resident] appeared to be very confused and lethargic. Nurses were aware of the resident's level of consciousness. On 12/27/19, a therapist note stated, The resident was very confused and was perseverating on 'going to the bathroom' . The therapist talked to the nurse regarding changes with behavior and increased confusion. Further review of facility documentation failed to reveal any evidence that a physician or Nurse Practitioner had been made aware of the findings expressed by the Therapists in these three notes. Review of healthcare provider progress notes from December, 2019, revealed that the resident's primary Nurse Practitioner (NP) wrote progress notes on 12/2, 12/4, 12/15, 12/16, 12/17, 12/20, and twice on 12/24. Additionally, the Medical Director wrote a history and physical for the resident on 12/12/19 after a one-day hospitalization . Although the progress note on 12/2 addresses cognitive changes, and the progress note on 12/4 addresses aggression, no physician or nurse practitioner (NP) note written after 12/4 addressed cognitive or behavioral changes at all. No new orders could be found following any of the three episodes noted above. The Director of Nursing was made aware of the above concerns on 2/24/20 and was asked to provide documentation that the resident's cognitive and behavior changes on 12/16, 12/22, and 12/27 were evaluated and treated by the resident's primary provider, or that the changes on 12/22 and 12/27 were responded to by the resident's psychiatric services. No additional evidence was supplied by the end of the survey.

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	215161	A. Building B. Wing	02/24/2020

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical record and interview with facility staff, it was determined that the facility failed to ensure that a resident with cognitive changes and worsening behaviors recevied sufficient assessment and treatment to address those behaviors. This was evident for 1 (Resident #2) of 7 residents reviewed during the survey. The findings include: In the course of investigating Complaint #MD 333, Resident #2's responsible party (RP) was contacted for interview on 2/20/20 at 12:39 PM. During the interview, the RP stated that Resident #2 demonstrated increased confusion, combativeness, and inappropriate or destructive behaviors in December, 2019. The RP stated these behaviors first became evident after the resident sustained [MEDICAL RECORD OR PHYSICIAN ORDER] . However, the RP noted that the behaviors increased in severity and frequency much more rapidly in December. The RP asserted that the facility failed to satisfactorily address these changes, allowing the resident to worsen without explanation or treatment. Resident #2's medical record was reviewed on 2/21/20 at 9:25 AM. During the review, progress notes from multiple disciplines demonstrated that Resident #2 was experiencing significant confusion and had behaviors that were inappropriate and sometimes destructive in December 2019. On 12/1/19, a progress note documented that the resident pulled a nursing assistant's lanyard (badge holder) on her neck but then the resident had become calm and apologetic. On 12/3/19, a progress note documented that the resident was given [an inhaler] to use and the resident put the wrong end into his/her mouth to administer to self. On 12/4/19, a progress note documented that the resident was screaming or pulling on the call light, unable to express his/her needs. On 12/6/19, a progress note documented that the resident appears to be very confused at this time. On 12/8/19, a progress note documented that the resident was yelling off and on through the night stating 'let me up, let me up.' On 12/12/19, a progress note documented that the resident broke the call light twice by ripping it out of the wall, then denied it. On 12/14/19 , a progress note documented that the resident was calling for maintenance to take him/her home to his/her car. On 12/15/19, a progress note documented that the resident said, I did not murder the girl, and go get my car parts. Although the above progress notes documented episodes of confusion and inappropriate behavior, three notes in particular indicated that the resident's cognition had worsened from baseline. On 12/16/19, a therapist note stated, The therapist talked to the nurse and rehab team about changes in the resident's behavior. He stated that the resident has become more resistive with exercises and increased confusion were observed. On 12/22/19, a therapist note stated, The [resident] appeared to be very confused and lethargic. Nurses were aware of the resident's level of consciousness. On 12/27/19, a therapist note stated, The resident was very confused and was perseverating on 'going to the bathroom' . The therapist talked to the nurse regarding changes with behavior and increased confusion. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	02/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of healthcare provider progress notes from December 2019, revealed that the resident's primary Nurse Practitioner (NP) wrote progress notes on 12/2, 12/4, 12/15, 12/16, 12/17, 12/20, and twice on 12/24. Additionally, the Medical Director wrote a history and physical for the resident on 12/12/19 after a one-day hospitalization . Although the progress note on 12/2 addresses cognitive changes, and the progress note on 12/4 addresses aggression, no physician or Nurse Practitioner (NP) note written after 12/4 addressed cognitive or behavioral changes at all. No new orders could be found following any of the three episodes noted above. Further review of the resident's medical record revealed [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of the medical record failed to review that this urine sample had ever been acquired. Further review of the resident's medical record revealed [MEDICAL RECORD OR PHYSICIAN ORDER] . However, the most recent evaluation was dated 12/19/19. No evaluation could be found following either the findings of 12/22/19 or of 12/27/19 as noted above. The Director of Nursing was made aware of the above concerns on 2/24/20 and was asked to provide documentation that the resident's cognitive and behavior changes on 12/16, 12/22, and 12/27 were evaluated and treated by the resident's primary provider, or that the changes on 12/22 and 12/27 were responded to by the resident's psychiatric services. No additional evidence was supplied by the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	02/24/2020

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on review of resident medical records and interview with facility staff, it was determined that the facility failed to ensure that resident records were complete and accurate as evidenced by Resident #6's medical record failing to include documentation of resident-to-resident abuse and notification following that event. This was evident for 1 (Resident #6) of 1 resident reviewed during the complaint survey. The findings include: The facility's investigative material for Facility Reported Incident #MD 136 was reviewed on 2/21/20 at 8:30 AM. The review revealed that, on 10/1/2019, Resident #6 was touched on the thigh by Resident #5 without consenting to such contact. The investigative material included documentation that Resident #6's responsible party had been notified of this event on 10/2/19. Resident #6's medical record was reviewed concurrently but no note could be found in the medical record that documented this event, nor any evidence that Resident #6's responsible party had been notified of the incident. The Director of Nursing (DON) was intereviewed on 2/24/20 at 11:00 AM. During the interview, the DON was requested to demonstrate that the medical record contained evidence of the event and that Resident #6's responsible party had been notified of the event. The DON provided the survey team with the same documents that were in the facility's original investigative material, but could not demonstrate that those documents were also being maintained in the resident's medical record so that all providers would have access to that information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	04/14/2021

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical record and interview with residents and facility staff, it was determined that the facility failed to ensure that residents remained free of sexual abuse perpetrated by Resident #25, resulting in actual harm for Residents #24 and #3. This was evident for 2 of 31 residents (Residents #24 and #3) reviewed during the survey. The findings include: The Brief Interview of Mental Status (BIMS) test is used to get a quick snapshot of cognitive function and is a required screening tool used in nursing homes to assess cognition. A score of 13 to 15 points indicates intact cognition, 8 to 12 points indicates moderately impaired cognition, and 0-7 points indicates severely impaired cognition. On 4/7/21 at 2:32 PM, surveyors reviewed a facility investigation that involved an encounter between Residents #24 and #25 that took place on 6/14/20. According to the investigation, on 6/14/20 at 4:45 PM, Certified Medication Aide (CMA) #8 went to Resident #24's room to administer afternoon medication and found the door closed. CMA #8 knocked on the door, entered, and observed Resident #25 standing beside Resident #24's bed. CMA #8 asked Resident #25 to leave the room. CMA #8 observed Resident #25 becoming verbally aggressive and coming toward her, so CMA #8 sought assistance from the Charge Nurse (Staff #10). The Charge Nurse intervened and redirected Resident #25 out of the room. However, by the time CMA #8 returned to the room to complete administration of Resident #24's afternoon medications, Resident #24 stated that Resident #25 was in here again checking my diaper and touching my [genitalia]. Further review of the facility's investigation revealed that Resident #24 received a full body assessment from Licensed Practical Nurse (LPN) #36 at 5:21 PM on 6/14/20. According to that assessment, Resident #24 denied pain or discomfort and showed no signs of physical injury. In response to the incident, a door alarm was placed on Resident #24's door on 6/14/20, and responsible parties for both residents, as well as the police, were notified of the incident the same day. Resident #24's medical record was reviewed on 4/7/21 at 2:32 PM. The review revealed that the resident was admitted to the facility in June 2009, with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The resident's most recent Brief Interview for Mental Status (BIMS) Assessment documented a score of 10 out of 15, indicating moderate cognitive impairment. (continued on next page)

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	215161	A. Building B. Wing	04/14/2021

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #25's medical record was reviewed by surveyors on 4/7/21. The review revealed that, prior to the events of 6/14/20, Resident #25 had been ordered 15-minute checks (in which the resident's status was documented on a form every 15 minutes) for 48 consecutive hours due to Resident #25 wandering into other residents' rooms. Those 15-minute checks were not active at the time that Resident #25 wandered into Resident #24's room on 6/14/20. It was also found that Resident #25's care plan had been modified on 6/14/20 to include one-to-one supervision, in which a specific staff member was responsible for supervising the resident at all times. Behavior-related interventions that were already in place on 6/14/20 included: 'Resident resides on secure unit,' 'Encourage activity participation for diversion,' 'Attempt to determine if resident is searching for something or a need is unmet,' 'Refer resident to psychiatry services,' 'Place on 15-minute checks for 48 hours,' and, 'Administer [CONDITION(S)] medication according to orders.' Resident #24 was interviewed on 4/12/21 at 11:20 AM. During the interview, Resident #24 was found to be alert but disoriented to time, place, and the situation. Resident #24 could not provide any details or communicate meaningfully about the incident involving Resident #25 that occurred on 6/14/20. CMA #8 was interviewed on 4/12/21 at 12:57 PM. During the interview, CMA #8 stated, I was the CMA on 6/14/20 and giving out medication when I went into [Resident #24's] room and found [Resident #25[standing over [Resident #24's] bed. [Resident #24] was fully clothed, and [Resident #25] was naked. [Resident #25] was manipulating the brief of [Resident #24] and touching [Resident #24's] genitalia. I asked [Resident #25] to leave the room, and s/he became agitated, so I left the room and got the Charge Nurse (Staff #10). CMA #8 indicated that Resident #25 must have entered the room again while she was getting help, because when she returned, Resident #24 stated, After [Resident #25] left my room, s/he came back and did it again. Review of Resident #25's medical record on 4/7/21 revealed that a psychiatric consult was ordered for Resident #25 on 6/14/20 and the resident was seen by Behavioral Health Nurse Practitioner (NP) #34 on 6/15/20. NP #34's report was found and stated, [Resident #25] was seen for urgent evaluation due to inappropriate behavior and danger to others. Labs were ordered last week, but the resident refused to complete labs. It is possible there is a medical condition impacting the resident's behavior. Resident was possibly exposed to COVID-19 (Coronavirus 2019) but was combative during the last rounds of universal testing. His/her behavior has been escalating, and s/he appeared with a flat affect and agitation. Resident has been wandering the halls and into other residents' rooms. S/he is difficult to redirect. S/he is currently at high risk to the safety of staff and other residents. S/he is currently on 1 to 1 supervision for behavior. Resident #24 was unable to provide additional information regarding the incident in interviews with the survey team. Further review of the incident report notes on 6/14/20 indicate that Resident # 24 told Resident # 25 to get out of here. This comment made by Resident # 24 demonstrated that the facility failed to keep Resident #24 from being sexually abused by Resident #25. 2) Resident #3's medical record was reviewed by surveyors on 4/8/21 at 11:24 AM. The review revealed that Resident #3 was admitted to the facility in October 2019, with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . A BIMS assessment completed at the time of admissions demonstrated a score of 2/15, indicating severely impaired cognition. (continued on next page)

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	215161	A. Building B. Wing	04/14/2021

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 4/8/21 at 11:24 AM, surveyors reviewed a facility investigation that involved an encounter between Residents #3 and #25 that took place on 7/25/20. According to the investigation, Geriatric Nursing Assistant (GNA) #9 found Resident #25 standing on a chair his/her room that Resident #3 was sitting in within Resident #25's room. Resident #25 was naked and performing sexual acts. Further review of the facility's investigation indicated that, following the incident, the Charge Nurse #10 performed a complete body assessment of both residents. No injuries were noted. The physicians and responsible parties for both residents, as well as the police, were made aware on the same day. Resident #25 remained on one-to-one supervision. Resident #25 was sent out to the hospital on 7/25/20 for a psychiatric evaluation and returned later the same day. Education about one-to-one observation was provided to all nursing staff by 7/30/20. Psychiatric consults were completed for both Residents #25 and #3, and both residents were evaluated by Social Worker #35. The facility documented no change in Resident #3's participation in activities, mental status, or mood, stating that Resident #3 continued to follow his/her daily routine. A door alarm was placed on Resident #25's door on 7/25/20 to prevent other residents from entering the room. Further review of Resident #3's medical record on 4/8/21 at 11:24 AM revealed a physician progress notes [MEDICAL RECORD OR PHYSICIAN ORDER] . The note indicated that Resident #3 could not be assessed due to severe dementia and cognitive impairment but continued to take four [CONDITION(S)] medications for mood. Physician #23 documented that Resident #3 did not appear to be in any distress. An interview was attempted with Resident #3 on 4/13/21 at 11:30 AM. The resident was not able to participate in the interview. Despite being ordered one-to-one supervision for Resident #25 after the 6/14/2020 incident with Resident #24, the facility failed to protect Resident #3 from being sexually abused by Resident #25.

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	215161	A. Building B. Wing	04/14/2021

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, review of residents' medical records, and interviews with residents and facility staff, it was determined that the facility failed to ensure that the responsibility for Resident #5's wound care was clearly defined between the resident and facility staff. This was evident for 1 (Resident #5) of 7 residents reviewed for complaints during the survey. The findings include: Resident #5 was interviewed on 4/7/21 at 9:36 AM. During the interview, Resident #5 indicated that s/he is responsible for doing his/her own wound care. The resident stated that s/he has chronic wounds on the lower parts of both of his/her legs. The resident pointed to a container at the sink that had multiple wound care supplies in it. The surveyor made observation of this wound care supply bin at that time, and noted that the bin had supplies including gauze, bandages, antibacterial wound care products, and silk tape. The resident stated that the wound care nurse would come visit him/her about once each week, would look at the wound, and would provide ordered wound treatment. Resident #5 said that, besides the Wound Care Nurse, no other nursing staff provided wound care for him/her. The resident, also, said that a physician and a nurse practitioner evaluated him/her and stated that s/he was safe to provide his/her own wound care. On 4/7/21 at 11:05 AM, an interview was performed with Licensed Practical Nurse (LPN) #30. During the interview, LPN #30 indicated that Resident #5 has daily wound care orders but will almost always refuse to have nursing staff perform that wound care. LPN #30 wasn't aware that any wound care supplies were in the resident's room. On 4/7/21 at 12:46 PM, an interview was conducted with the Wound Care Nurse. During the interview, the Wound Care Nurse indicated that Resident #5 had chronic wounds on both of his/her lower legs related to poor blood circulation. The Wound Care Nurse stated that Resident #5 would often refuse his/her wound treatment from other nursing staff, and stated that Resident #5 recently told her about a month ago that the Wound Care Nurse is the only staff person performing his/her wound treatment. During the interview, the Wound Care Nurse said that Resident #5 was not competent to perform his/her own wound care, emphasizing that the resident could not adequately reach his/her legs to perform the dressing change. Nevertheless, Resident #5 would often ask about doing his/her own dressing change, and was evaluated by Nurse Practitioner (NP) #36 and Physician #23 regarding his/her competency to self-perform. The Wound Care Nurse said that Resident #5 was not cleared by those staff to perform his/her own dressing changes as a result of those evaluations. The Wound Care Nurse stated that if a resident were cleared to perform their own dressing changes, there would be an active order stating he or she were capable of performing their own dressing change. There would also be a specific competency form filled out. The Wound Care Nurse was not aware that there were any wound care supplies at the bedside for the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	04/14/2021

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5's medical records were reviewed on 4/7/21 at 1:19 PM. During the review, five active wound care order were found: one with a start date of 7/14/20 and four with a start date of 2/12/21. None of the orders indicated that the resident was to perform his/her own dressing change. The review also revealed a physician's progress note dated 3/18/21 from Physician #23 that stated, [Resident #5] is frequently refusing his/her dressing care. S/he was observed and educated to do self wound care since s/he has been refusing to get care from nursing staff. Primary team and Wound Care Nurse is available to do his/her wound care whenever s/he allows us to provide care. Ongoing review of Resident #5's medical records revealed a care plan stating, [Resident #5] exhibits mood and behavior problems: verbal aggression, physical aggression, care refusals . with the approaches, Discourage inappropriate behavior [including care refusal], and, encourage and praise appropriate behavior . No care plan was found stating that the resident was to provide wound care independently.

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	215161	A. Building B. Wing	04/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident medical records and interview with facility staff, it was determined that the facility failed to provide adequate supervision to prevent residents with sexually inappropriate behaviors from perpetrating sexual abuse on other residents. This was evidenced by Resident #25, who had a history of wandering behavior, was confused, and had a diagnosis of dementia with behavioral disturbance including sexual inappropriateness, making nonconsensual sexual contact with Resident #24 in June 2020, and then again with Resident #3 in July 2020. The facility's failure to provide adequate supervision to Resident #25 resulted in actual harm to both Residents #24 and Resident #3. The deficient practice was evident for 1 of 15 residents (Resident #25) reviewed for wandering and sexually inappropriate behaviors. The findings include: The MDS (Minimum Data Set) is a comprehensive assessment of the resident which provides the facility with the information necessary to develop a plan of care. A care plan is a guide that addresses the unique needs of each resident. It is used to assess and plan for the resident's care needs and to evaluate the effectiveness of the resident's care. The Brief Interview of Mental Status (BIMS) test is used to get a quick snapshot of cognitive function and is a required screening tool used in nursing homes to assess cognition. A score of 13 to 15 points indicates intact cognition, 8 to 12 points indicates moderately impaired cognition, and 0-7 points indicates severely impaired cognition. 1) On 4/7/21 at 2:32 PM, Surveyors reviewed a facility investigation that involved an encounter between Residents #24 and #25 that took place on 6/14/20. According to the investigation, on 6/14/20 at 4:45 PM, Certified Medication Aide (CMA) #8 went to Resident #24's room to administer afternoon medication and found the door closed. CMA #8 knocked on the door, entered, and observed Resident #25 standing beside Resident #24's bed. CMA #8 asked Resident #25 to leave the room. CMA #8 observed Resident #25 becoming verbally aggressive and coming toward her, so CMA #8 sought assistance from the Charge Nurse (Staff #10). The Charge Nurse intervened and redirected Resident #25 out of the room. However, by the time CMA #8 returned to the room to complete administration of Resident #24's afternoon medications, Resident #24 stated that Resident #25 was in here again checking my diaper and touching my [genitalia]. Further review of the facility's investigation revealed that Resident #24 received a full body assessment from Licensed Practical Nurse (LPN) #36 at 5:21 PM on 6/14/20. According to that assessment, Resident #24 denied pain or discomfort and showed no signs of physical injury. In response to the incident, a door alarm was placed on Resident #24's door on 6/14/20, and responsible parties for both residents, as well as the police, were notified of the incident the same day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	04/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlotte Hall Veterans Home	29449 Charlotte Hall Road Charlotte Hall, MD 20622

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #24's medical record was reviewed by the surveyors on 4/7/21 at 2:40 PM. The review revealed that the resident was admitted to the facility in June 2009, with diagnoses including [CONDITION(S)], dementia with behavioral disturbance, and paranoid [CONDITION(S)]. A BIMS assessment performed at the time of admission indicated that Resident #24 had a score of 10 out of 15, indicating moderate cognitive impairment. Resident #25's medical record was reviewed by surveyors on 4/7/21. The review revealed that Resident #25 had a BIMS score of 2/15, indicating severe cognitive impairment and prior to the events of 6/14/20, Resident #25 had been ordered 15-minute checks on 6/10/20 (in which the resident's status was documented on a form every 15 minutes) for 48 consecutive hours due to Resident #25 wandering into other residents' rooms. Those 15-minute checks were not active at the time that Resident #25 wandered into Resident #24's room on 6/14/20. It was, also, found that Resident #25's care plan had been modified on 6/14/20 to include one-to-one supervision, in which a specific staff member was responsible for supervising the resident at all times. The behavior-related interventions that were already in place on 6/14/20 included: 'Resident resides on secure unit,' 'Encourage activity participation for diversion,' 'Attempt to determine if resident is searching for something or a need is unmet,' 'Refer resident to psychiatry services,' 'Place on 15-minute checks for 48 hours,' and 'Administer [CONDITION(S)] medication according to orders.' Further review of Resident #25's medical record revealed that a psychiatric consult was ordered for Resident #25 on 6/14/20 and the resident was seen by Behavioral Health Nurse Practitioner (NP) #34 on 6/15/20. NP #34's report was found and stated, [Resident #25] was seen for urgent evaluation due to another inappropriate behavior with another resident and danger to others. Labs were ordered last week, but the resident refused to complete labs. It is possible there is a medical condition impacting the resident's behavior. Resident was possibly exposed to COVID-19 (Coronavirus 2019) but was combative during the last rounds of universal testing. His/her behavior has been escalating, and s/he appeared with a flat affect and agitation. Resident has been wandering the halls and into other residents' rooms. S/he is difficult to redirect. S/he is currently at high risk to the safety of staff and other residents. S/he is currently on 1 to 1 supervision for behavior. Further review of Resident #25's medical record revealed that Resident #25 was transferred from Resident #24's unit on 6/17/20 at 12:05 PM. The resident was relocated to C Unit, a secured unit in which residents required staff to enter a code at the unit's exit to leave the unit. Resident #25 continued to receive one-to-one monitoring on that unit. A physician's note, dated 6/16/20, documented, [Resident #25] with behaviors due to dementia, has worsening behaviors . Will continue [MEDICATION(S)] and [MEDICATION(S)] awaiting inpatient psychiatry eval and medication review . Care plan was in place for sexual socially inappropriate behavior, touching other residents. Responsible party of [resident #25] was notified and stated, 'Please tell [Resident #25] I love him/her and thank all of you for doing a great job. Resident #25's medication orders were reviewed on 4/7/21. The review revealed that Resident #25 was ordered [MEDICATION(S)] 20mg (an antipsychotic medication) on 6/18/20. Resident #24 was interviewed on 4/12/21 at 11:20 AM. During the interview, Resident #24 was found to be alert but disoriented to time, place, and the situation. Resident #24 could not provide any details or communicate meaningfully about the incident involving Resident #25 that occurred on 6/14/20. (continued on next page)

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	215161	A. Building B. Wing	04/14/2021

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Charlotte Hall Veterans Home	29449 Charlotte Hall Road Charlotte Hall, MD 20622

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CMA #8 was interviewed on 4/12/21 at 12:57 PM. During the interview, CMA #8 stated, I was the CMA on 6/14/20 and giving out medication when I went into Resident #24's room and found Resident #25 standing over Resident #24's bed. Resident #24 was fully clothed, and Resident #25 was naked. Resident #25 was manipulating the brief of Resident #24 and touching Resident #24's [genitalia.] I asked Resident #25 to leave the room, and s/he became agitated, so I left the room and got the Charge Nurse (Staff #10). CMA #8 indicated that Resident #25 must have entered the room again while she was getting help, because when she returned, Resident #24 stated, After [Resident #25] left my room, s/he came back and did it again. Also, Resident #24 stated to CMA #8, I told [Resident #25] to get out of here. Charge Nurse #10 was interviewed on 4/8/21 at 3:10 PM. During the interview, Charge Nurse #10 stated, Resident #25 wandered all over the unit and went in and out of other resident rooms. Sometimes Resident #25 was redirectable and sometimes not. Resident #25 appeared to listen more to men than to women when being redirected. Resident #24 was unable to provide additional information regarding the incident in interviews with the survey team. Further, review of Resident #25's medical record demonstrated a history of wandering and sexually inappropriate behavior prior to the incident on 6/14/20. The facility's failure to provide adequate supervision to Resident #25 resulted in Resident #24 being sexually abused by Resident #25. 2) On 4/8/21 at 11:24 AM, surveyors reviewed a facility investigation that involved an encounter between Residents #3 and #25 that took place on 7/25/20. According to the investigation, Geriatric Nursing Assistant (GNA) #9 found Resident #25 standing on chair in h/her room, that Resident # 3 was sitting in. The room that belonged to Resident # 25. Resident #25 was naked and performing sexual acts. Despite being ordered one-to-one supervision, Resident #25 had last been seen in the breakfast room an hour and a half prior to the incident. Further review of the facility's investigation indicated that, following the incident, the Charge Nurse (Staff #10) performed a complete body assessment of both residents. No injuries were noted. The physicians and responsible parties for both residents, as well as the police, were made aware on the same day. Resident #25 remained on one-to-one supervision. Resident #25 was sent out to the hospital on 7/25/20 for a psychiatric evaluation and returned later the same day. Education about one-to-one observation and abuse was provided by staff educator # 37 to all employees and was completed by 7/30/20. Psychiatric consults were completed for both Residents #25 and #3, and both residents were evaluated by Social Worker #35. The facility documented no change in Resident #3's participation in activities, mental status, or mood, stating that Resident #3 continued to follow his/her daily routine. A door alarm was placed on Resident #25's door on 7/25/20 to prevent other residents from entering the room. Review of Resident #25's medical record on 4/8/21 revealed that Behavioral Health Nurse Practitioner (NP) #34 ordered Resident #25 additional antipsychotic medication following the events of 7/25/20. Resident #25's attending physician also ordered blood laboratory testing following the event. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	04/14/2021

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F 0689 Level of Harm - Actual harm Residents Affected - Few	GNA #9 was interviewed on 4/13/21 at 3:00 PM. During the interview, GNA #9 stated that he was called in to work and arrived at the facility at 8:00 AM, an hour after the day shift had begun. Upon arrival to the facility, GNA #9 was notified that he was assigned to provide one-to-one supervision to Resident #25 for the shift. After arriving on Resident #25's unit, GNA #9 discovered that no staff were actively observing Resident #25. GNA #9 then located Resident #25 in his/her room, where he saw Resident #25 standing on the same chair that Resident #3 was sitting in. The chair was actually on Resident #25's side of the room. Resident #3 was fully clothed. Resident #25 was standing with feet planted on either side of Resident #3's thighs. Resident #25 was naked, with pelvis and genitalia facing Resident #3's face. Resident #25 was moving his/her hips back and forth. GNA #9 stated that he shouted for help and that Charge Nurse #10 responded, helping to remove Resident #3 from the room. In the same interview, GNA #9 indicated that the night shift staff person who was performing one-to-one supervision for Resident #25 had left around 7:00 AM, and that Charge Nurse #10 had not assigned a replacement until GNA #9 arrived on the unit, which was 8:15 AM. Resident #3's medical record was reviewed by surveyors on 4/8/21 at 11:24 AM. The review revealed that Resident #3 was admitted to the facility in October 2019, with diagnoses including Alzheimer's disease, dementia with behavioral disturbances, affective disorder, and anxiety. A BIMS assessment completed at the time of admissions demonstrated a score of 2/15, indicating severely impaired cognition. Resident #3 was deemed by two physicians on 10/10/19 as unable to understand the nature, extent, or probable consequences of proposed treatments, unable to make rational evaluations of the burdens, risks, and benefits of treatment and unable to effectively communicate a decision. A physician progress notes from Physician #23 dated 7/30/20 at 12:39 PM indicated that Resident #3 had severe dementia and cognitive impairment but continued to take four [CONDITION(S)] medications for mood. Physician #23 documented that Resident #3 did not appear to be in any distress during the physical exam and the mental exam. Resident # 3 could not recall the incident. Resident #3 reported having a good weekend and responded, No, when asked if he/she had any concerns. Resident #3 responded, I feel fine' when asked if he/she felt safe at the facility. An interview was attempted with Resident #3 on 4/13/21 at 11:30 AM. The resident was not able to participate in the interview. The facility's lack of supervision of Resident #25 resulted in Resident #3 being sexually abused by Resident #25. The Director of Nursing and Nursing Home Administrator were made aware of the above concerns on April 12, 2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	04/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlotte Hall Veterans Home	29449 Charlotte Hall Road Charlotte Hall, MD 20622

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of residents' medical records and interview with facility staff, it was determined that the facility failed to ensure that each dose of as-needed pain medication given to Resident #6 was assessed after administration for effectiveness. This was evident for 1 (Resident #6) of 7 residents reviewed for complaints during the survey. The findings include: Pain medication can be ordered for residents either on a schedule or as-needed. As-needed orders (PRN) are given when a resident requires additional medication to manage fluctuating pain levels. Pain can be measured by verbal report, where a resident scores pain from 1-10, or can be assessed by healthcare providers using nonverbal scales. Regardless of method, as-needed pain medication must be monitored for effectiveness by performing pain assessments both before and after administration of as-needed pain medication. Failure to assess effectiveness after administration can lead to a resident's pain being inadequately managed, or to negative side effects of strong pain medication going unaddressed. Resident #6's medical record was reviewed on 4/6/21 at 10:25 AM. During the review, it was found that Resident #6 was ordered [MEDICATION(S)] 100 miligrams / 5 mililiters concentraion. Give 0.25 mililiters (5 miligrams) [under the tongue] every four hours as needed for pain / [trouble breathing]. This order was effective on 9/19/19 as part of hospice orders, and the order was discontinued when the resident passed away on 10/1/19. Between 9/19/19 and 10/1/19, Resident #6 received a total of 16 doses of [MEDICATION(S)]: once on 9/24/19, once on 9/25/19, once on 9/26/19, three times on 9/27/19, three times on 9/28/19, four times on 9/29/19, once on 9/30/19, and twice on 10/1/19. Ongoing review of Resident #6's medical record revealed that follow up assessments of the effectiveness of doses of [MEDICATION(S)] were performed for only one dose: a follow-up note for the administration on 9/29/19 at 4:23 AM was written as a nursing note on 9/29/19 at 7:13 AM. No other post-assessment could be found for administration of [MEDICATION(S)]. The Assistant Directors of Nursing (Staff #3 and Staff #11) were interviewed on 4/9/21 at 1:30 PM. Both confirmed that there was no additional evidence of post-administration assessment of the effectiveness of Resident #6's [MEDICATION(S)] doses.

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	215161	A. Building B. Wing	04/14/2021

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of residents' medical records and interviews with residents and facility staff, it was determined that the facility failed to maintain accurate records of Resident #5's participation in activities. This was evident for 1 (Resident #5) of 7 residents reviewed for complaints during the survey. The findings include: Resident #5 was interviewed on 4/7/21 at 9:36 AM. During the interview, Resident #5 indicated that s/he did not like to participate in group activities, preferring to remain in his/her room exclusively. The Activities Director (Staff #37) was interviewed on 4/7/21 at 12:21 PM. During the interview, the Activities Director stated that Resident #5 had a history of [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #5's medical record was reviewed on 4/7/21 at 1:15 PM. During the review, a care plan was found for activities that stated, Resident has stated a preference for independent self directed activities such as watching television, using his/her computer, going outside for fresh air. The review, also, revealed an initial activity assessment completed on 4/18/20 that indicated Resident #5 preferred to engage in activities in his/her own room. Activities logs for February and March, 2021, were provided by the Activities Director around 1:30 PM on 4/7/21. The logs indicated that Resident #5 participated in 'socials' activities 16 times in February, 2021, and that the resident was actively engaged during each one. The logs, also, indicated that Resident #5 participated in 'Reading (Group)' activities 16 times in March, 2021, and that the resident was actively engaged during each one. Activity Aide #39 was interviewed on 4/8/21 at 9:29 AM. During the interview, Activity Aide #39 indicated that Resident #5 often declined activities, even though the Aide offered activities to Resident #5 whenever she was on Resident #5's unit. The aide confirmed that she had completed the February and March, 2021, activity logs for Resident #5 and stated, When I wrote 'social' activity, I meant that I went in and greeted him/her. When I wrote 'Reading activity (group),' I meant that s/he was given the daily chronicle.

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	215161	A. Building B. Wing	08/15/2022

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, it was determined that the facility failed to identify the need to discontinue the use of plastic utensils and maintaining the dignity for a resident when s/he was no longer deemed unsafe. This was evident during the review of a facility reported incident. The findings include: During initial tour and observation of Resident #77 on 7/25/2022 and 7/26/2022, s/he was observed eating lunch and breakfast respectively with other residents, however, s/he was noted with plastic utensils while the other residents had silverware. Resident #77 was interviewed on 7/26/2022 at 9:00 AM. S/he did not address the use of the plastic utensils though prompted by the surveyor. Review of the medical record on 7/28/2022 at 8:35 AM for Resident #77 revealed diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Further review of the medical record revealed an incident from 4/21/2022 where Resident #77 admitted to self-harming. Interventions were immediately put into place by the facility including for the use of plastic utensils and including him/her in the facility behaviors committee. Interview with the facility Social Worker, staff #20, responsible for the behavior committee on 7/28/2022 at 9:44 AM revealed that the behavior committee meets once a week. She further reported that Resident #77 had since 'graduated' meaning that after continued review and monitoring s/he had improvement in mood after the initiation of new medication and had returned to his/her baseline. This was noted to have occurred on 5/12/2022. The Surveyor reported the concern to the Director of Nursing (DON) on 7/28/2022 that Resident #77 was documented as having returned to 'baseline' on 5/12/2022 and still showing no signs of self-harm, however, the care planned intervention for plastic utensils remains in place. On 7/29/2022 at 6:57 AM the DON reported to the survey team that the care plan and order for Resident #77 has been updated to reflect s/he no longer has to use plastic utensils.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	08/15/2022

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility investigative material, it was determined that facility staff failed to change a resident when needed. This is evident for 1 (Resident # 222) out of 59 residents reviewed for facility reported incidents. The findings include: A medical record review and incident report for abuse was conducted on 8/11/22 at 8:15 AM. The review revealed that Resident #222 was admitted to this facility in November 2018. His/her diagnoses included muscle spasms, reduced mobility, stroke, and [CONDITION(S)] stage 3. The resident also suffers from [CONDITION(S)], anxiety and has a care plan for making false accusations against staff. On 4/14/19 at 11:15 PM, Resident #222 accused staff of being verbally abusive and rude. The resident stated that Geriatric Nursing Assistant (GNA) #83 threw his/her clothes on the wheelchair in his/her room and held up a diaper where s/he could see it and stated this diaper is not wet. Resident #222 stated that the diaper was soaking wet. The resident also stated that the GNA said to him/her that s/he was abusive with the call light and stated, that is why your family doesn't want to take care of you. Review of resident records and interviews obtained by staff investigating the alleged incident revealed that, on 4/14/19, GNA #83 worked on the 3-11 PM shift and was assigned to Resident #222. At 4:15 PM, Resident #222 used his/her call bell and asked to be changed. GNA #83 responded, ok, and changed his/her diaper. The GNA also stated that the next diaper change time would be at 6:15 PM. Resident #222 responded, OK. The GNA then went to other rooms to take care of other residents. During that time, Resident #222 rang the call bell again and other GNAs responded. At 6:15 PM, GNA #83 went into Resident #222's room and changed him and told him the next change would be at 8:15 PM. The record review revealed that later, another GNA came and told GNA #83 that she changed Resident #222 at 7:15 PM. GNA #83 said to the other GNA that its not time to change him. He should be changed at 8:15 PM and to tell Resident #222 that since he got changed early his next change will be at 10:15 PM. At 9:00 PM, GNA #83 took her break and was sitting in the day room when Resident #222's call bell went off. GNA #83 and another GNA got up from the break room and entered Resident #222's room. Resident #222 stated s/he needed to be changed. Record review revealed further that GNA #83 told Resident #222 that it was not time to be changed and the next scheduled time for him/her to be changed would be at 10:15 PM. Both GNAs left the room. The administrative team was made aware of this dignity issue on 8/11/22. GNA #83 was inserviced for Resident Rights when she returned to work after being suspended.

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	215161	A. Building B. Wing	08/15/2022

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interviews and record reviews it was determined the facility failed to ensure that residents were given a choice to have a shower. This was found to be evident for 2 out 2 Residents (#124 & #171) reviewed for bathing. The findings include: On 07/27/2022 at 9:00 AM during an interview conducted, Resident #124 stated he/she had not received showers twice a week as scheduled. The Resident further stated he/she had spoken with Geriatric Nursing Assistants (GNAs) and nurses that he had wanted his/her biweekly showers however the resident was given bed baths. A record review of the Whirlpool and Shower schedule conducted on 07/28/2022 at 11:15 AM revealed that Resident #124's shower days were on Tuesday and Saturday of each week. On 07/29/2022 at 07:11 AM a record review of the echart completed care was conducted for the timeframe of 02/01/2022 to 07/29/2022. The record review confirmed the resident did not receive showers as scheduled. Resident #124 received showers on 02/21/2022, 3/26/2022, 04/08/2022, 04/12/2022, 04/15/2022, 04/19/2022 ,04/20/2022, 04/26/2022, 05/03/2022, 05/06/2022, 05/13/2022, 5/20/2022, 06/03/2022, 06/17/2022, 07/01/2022, 07/08/2022, 07/15/2022, and 07/26/2022. Further review of the echart completed care revealed no documentation that the resident refused showers during the timeframe of 02/01/2022 - 07/29/2022. During an interview conducted on 07/28/2022 at 10:35 AM, Resident #171 stated he/she had not been given showers as scheduled biweekly instead he/she had been given bed baths. The Resident stated that he/she had requested showers but continued to receive bed baths. On 07/29/2022 at 08:46 AM, a record review was conducted for Resident # 171 Whirlpool and Shower schedule. The schedule revealed the resident was scheduled for showers on Sunday and Thursday each week. On 07/29/2022 at 10:09 AM a record review of the echart completed care was conducted for the timeframe of 02/1/ - 07/29/2022. The record review revealed, Resident #171 received a shower on 03/15/2022, 04/11/2022, and 06/16/2022 and confirmed that the resident did not receive the scheduled biweekly showers. Further review of the echart completed care revealed no documentation that the resident refused showers during the timeframe for 02/01/2022 - 07/29/2022. During an interview conducted on 07/29/2022 at 11:30 AM, the Director of Nursing (DON) stated the facility's expectation is that the staff provide the residents their scheduled showers. The DON further stated if the resident refused a shower the staff are expected to document the shower refusal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident record review, and staff and resident interviews, it was determined that the facility failed to: 1) ensure that residents were free from abuse (Resident #17); 2) ensure that residents were free from neglect (Resident #10); 3) maintain adequate supervision of residents with documented histories of aggressive behavior with care planned interventions in place including to perform routine checks to prevent potential 'inappropriate,' and 'aggressive' behavior (Resident #187); and 4) prevent abuse occuring from an employee towards a resident (Resident #235). This was found to be evident for 4 out of 49 residents reviewed for abuse and neglect. As a result of this failure, actual harm was identified for Resident #17. The findings include: 1) A review of the nurse's notes for Resident #17 was conducted on 08/09/2022 at 9:00 AM. The nurses note stated on 05/27/2022 at approximately 4:20 PM the Unit Manager # 42 was told by Resident #17 and his/her roommate Resident # 148 that Geriatric Nursing Assistant (GNA) #74 bent Resident #17's right thumb back. The Unit Manager #42 assessed the resident's right thumb and concluded the thumb appeared abnormal. A physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . A review of the hospital discharge summary on 08/09/2022 at 9:10 AM revealed Resident #17 was diagnosed with a dislocation of the right thumb in 05/27/2022. BIMS stands for Brief Interview for Mental Status. The BIMS test is used to get a quick snapshot of how well you are functioning cognitively at the moment. It is a required screening tool used in nursing homes to assess cognition. The resident can score 0 to 15 points on the test. A score of 13 to 15 suggests the patient is cognitively intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment. During an interview conducted on 08/09/2022 at 9:25 AM, Resident #17 with a Brief Interview of Mental Status (BIMS) of 8 stated GNA # 74 came into the resident's room and questioned what he/she was doing with the pillows. The resident stated he/she wanted to have someone to put his pillows in the closet. According to the resident, the GNA began to yell at him/her because the resident did not want the pillows on the bed. The resident further stated the GNA was very mad and grabbed the resident's right thumb, twisted, and pulled his/her thumb back. During an interview conducted on 08/09/2022 at 9:32 AM, Resident #148 (Resident #17's roommate) with a BIMS of 15 stated he /she witnessed GNA #74 yell at Resident#17 and bend the resident's right thumb all the way back. An interview conducted on 08/09/2022 at 10:27 AM, the Unit Manager #42 stated she was told by Resident #17 and Resident #148 on 05/27/2022 that GNA #74 bent Resident #17's right thumb back. The Unit Manager stated she assessed the resident's thumb, obtained a physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview conducted on 08/10/2022, the Administrator stated GNA #74 was suspended on 05/27/2022 pending an investigation and terminated as result of the facility's investigation. On 08/09/2022 a review of the facility's investigation confirmed the facility suspended GNA #74 pending the facility's investigation and then terminated the GNA based on the results of the investigation. The facility reported the GNA to the Board of Nursing for the abuse of the resident. 2) During an interview conducted on 07/25/2022 at 10:00 AM, Resident #10 stated he/she was left alone in the whirlpool bathtub by GNA #88. The resident stated he/she was fearful that he/she would have slid under the water because of his/her lack of muscle strength. The resident stated he/she yelled for help, the staff came and removed him/her from the whirlpool bathtub. The surveyor asked if the resident had slid under the water, the resident stated no; the resident was asked if he/she received whirlpool baths since the incident, the resident stated no and that he/she never liked a whirlpool bath. The resident further stated the incident did not cause him/her to be fearful of a whirlpool bath or any other type of bath. An interview conducted on 07/25/2022 at 10:22 AM, the Unit Secretary #8 stated she was present at the time of the incident. The Unit Secretary stated the resident is a transfer by Hoyer lift. On the day of the incident the GNA [NAME] the resident to the whirlpool bath in his/her wheelchair. The GNA Hoyer lifted the resident out of the wheelchair and into the whirlpool bathtub. The resident remained on the Hoyer lift with the Hoyer lift pads under him/her. The GNA#88 left Resident #10 inside the whirlpool bathtub on the Hoyer lift. Several minutes later the resident yelled for help and several staff ran into the whirlpool bathtub room. The resident was Hoyer lifted out of the whirlpool and assessed. [CONDITION(S)] is a genetic condition that affects the nervous system and causes movement problems. People with this condition develop impaired muscle coordination (ataxia) that worsens over time. Other features of this condition include the gradual loss of strength and sensation in the arms and legs; muscle stiffness ([CONDITION(S)]); and impaired speech, hearing, and vision. On 07/25/2022 at 1:27 PM a review of the Resident #10's medical record revealed the resident had a diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . On 07/29/2022 at 1:22 PM a review of the facility's investigation revealed the facility suspended GNA #88 pending the investigation on the day of the incident 03/15/2022. After viewing camera footage, the facility determined GNA #88 left Resident #10 in the whirlpool bathtub for 8 minutes and the GNA was immediately terminated. On 08/01/2022 at 7:15 AM review of Resident #10's Psychiatric note dated 03/16/2022 stated resident anxious and tearful following being left in the whirlpool bath for an extended period of time. On 08/01/2022 at 7:16 AM review of Resident #10's psychiatric note 03/24/2022 stated/noted the resident was back to baseline and stated/noted that he was doing fine. Resident stated he wishes to get showers instead of baths. (continued on next page)

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	215161	A. Building B. Wing	08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlotte Hall Veterans Home	29449 Charlotte Hall Road Charlotte Hall, MD 20622

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 08/01/2022 at 10:50 AM the Surveyor advised the Administrator of the concern. The Administrator stated she recalled the incident. The Administrator stated that GNA #88 was first suspended immediately and after viewing the camera footage the GNA was immediately terminated. The facility immediately conducted bathtub safety in-services, and competency for mechanical lift and the resident's physician placed a new order for a shower chair and 2 caregiver assistants. On 08/01/2022 at 1:00 PM the Administrator provided the Surveyor with supportive documentation of the interventions implemented. Based on medical record review, interview, and observation of residents, it was determined that the facility failed to: 1. maintain adequate supervision of residents with documented histories of aggressive behavior with care planned interventions in place including to perform routine checks to prevent potential 'inappropriate,' and 'aggressive' behavior and 2. failed to prevent abuse occuring from an employee towards a resident. This was evident during the review of an abuse allegation between 2 residents (#187 and #235) and observations during tour. The findings include: 3) Surveyor reviewed the facility reported investigation into the resident-to-resident altercation between Resident #187 and #235 on 8/2/2022 at 7:25 AM that occurred on 5/26/2021. The report documented that the Charge Nurse, staff #18, was alerted to an altercation between 2 residents by another resident. Staff #18 responded and observed Resident #235 'stomping' on the head of Resident #187. The residents were separated, and Resident #187 was sent to the hospital for evaluation. Review of Resident #187 and #235 care plans both included interventions related to a history of aggressive behaviors documented towards staff and other residents requiring routine checks and monitoring, however, no staff were aware of either residents' status at the time of the incident according to the interviews provided in the facility investigation. Review of the medical record on 8/2/2022 at 7:34 AM for Resident #187 revealed diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . Additionally, on 10/10/2019 a care plan was initiated for aggressive behavior towards staff, this was reviewed as recent as 4/19/2021 and remained active at the time of the altercation. Resident #185's Brief Interview for Mental Status (BIMS 15-point cognitive screening measure that evaluates memory and orientation) at the time of the incident was not completed, the score was '99' as the resident was not a candidate cognitively to complete the exam. Review of the medical record for Resident #235 revealed diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Care plans reviewed revealed identified problems and goals in place from 3/17/2020 regarding numerous behavior problems such as aggression and territorial behavior with approaches including to perform routine checks on the resident. Social services assessed Resident #235 after the incident that occurred on 5/26/2021 on 5/27/2021 and determined that s/he had a BIMS score of 6/15 meaning that s/he had 'severe impairment' in cognitive functioning. Interview on 8/11/2022 at 9:05 AM with staff #15, the Regional Nurse Consultant, regarding what 'routine checks' was revealed the expectation was that staff would complete their usual 2-hour checks on the residents. In addition, their behaviors, if any, are documented every shift. (continued on next page)

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	215161	A. Building B. Wing	08/15/2022

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Regarding Resident #235, on the day of the incident 5/26/2021 at 10:02 AM, staff documented that s/he had exhibited behaviors and rejection of care. There was no additional documentation of monitoring, observations or interventions related to the already documented behaviors exhibited by Resident #235 on the afternoon of 5/26/2021 prior to him/her inflicting aggression on Resident #187 that led to his/her hospitalization . These findings and concerns were reviewed with the facility DON and Administrator throughout the survey and again on 8/11/2022. Cross reference with F610 4) On 8/7/2022 during a tour of the 2C unit at 2:30 PM, Resident #101 was observed sitting in the day room engaging with various activity mats that were available on the table in front of him/her. A female staff member was observed standing to the right of Resident #101. Surveyor continued tour of the facility with observations and interviews with other residents and staff. Upon walking up the hall towards the nursing station surveyor stopped at the day room to continue to make observations of Resident #101. The female staff member who is now identified as staff # 71 and also Resident #101's usual 1:1 was then observed aggressively pulling Resident #101 up in the chair by the residents' right arm, then threw the residents' right arm across his/her body and angrily stated 'stop that.' She then looked around and saw the Surveyor watching her. Surveyor approached the staff member to get her name and noted that her badge stated 'student.' Staff #71 stated that she was not a student that she had just graduated. The observed concerns were immediately reported to the nurse on duty, LPN staff #68 , then the facility Administrator who happened on the unit moments later. The Administrator immediately removed Staff #71 off the floor and took statements from her and all the staff present. The facility was notified of the concerns related to the observed abuse and inappropriate interaction between the employee who identified herself as a GNA, staff #71 towards Resident #101.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlotte Hall Veterans Home	29449 Charlotte Hall Road Charlotte Hall, MD 20622

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on record review, interview, and review of pertinent facility documents and policies, it was determined that the facility failed to thoroughly investigate an allegation of abuse. This was evident for * of * facility reported incidents reviewed. The findings include: Surveyor reviewed the facility reported investigation into the resident-to-resident altercation between Resident #187 and #235 on 8/2/2022 at 7:25 AM that occurred on 5/26/2021. The report documented that the Charge nurse, staff #18 was alerted to an altercation between 2 residents by another resident. According to Staff #18's statement he immediately responded and separated the two residents. Further review of the facility's' investigation failed to reveal the assignment schedule, which staff was assigned to which resident, in the investigation packet. According to the interviews in the packet no one observed anything until they were notified later that there was an 'incident.' The actual staff caring for the two residents were not identified, neither was the resident that alerted the Charge nurse of the incident. Review of Resident #187 and #235 care plans both included interventions related to behaviors needing routine checks and monitoring, however, no staff were aware of either residents' status or whereabouts at the time of the incident according to the statements provided in the facility investigation. On 8/3/2022 at 10:03 AM Surveyor requested the actual schedule for 5/26/2021 from the Director of nursing (DON) to determine if all staff was interviewed and who was assigned to the two residents. On 8/4/2022 at 7:08 AM the DON reported that she did not have the schedule, however, was able to see who documented on the residents and is contacting the employees now for statements but further stated that yes, there are no statements in the packet from those 2 identified employees that were on the schedule. The surveyor also reviewed with the DON that a statement regarding the incident was not requested from the resident that alerted the Charge nurse to the altercation. Surveyor reviewed the census for that unit on 8/3/2022 at 12:30PM. This review revealed that there were at least 3 residents residing on the unit at the time of the incident with a brief interview for mental status (BIMS 15-point cognitive screening measure that evaluates memory and orientation) over 10, showing they were only moderately impaired with one individual scoring a 13-meaning s/he was cognitively intact. Quality assurance staff #44 wanted to present her findings and investigation to the survey team on 8/11/2022 at 12:20 PM. She stated that she felt the investigation was thorough as she saw everything on video. She stated that no one was around, Resident #235 went after Resident #187, and she felt there was nothing further needed in the investigation that was provided. The concern that the survey team had requested any contributory investigative information for 2 weeks related to our identified concerns and nothing further was provided was reviewed with her at this time, in addition to the new concern that her findings related to the video was not in the investigation. (continued on next page)

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	215161	A. Building B. Wing	08/15/2022

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #235 had documented behaviors prior to the incident on the morning or 5/26/2021. Nothing related to this or interviews from his/her assigned staff was in the investigation or determination as to why witnesses (the resident who alerted the charge nurse) or other residents and staff were not interviewed regarding the incident. Completion of a thorough investigation allows a facility to implement timely and appropriate interventions for the safety of all involved. The concern that the facility failed to do a thorough investigation, including interviewing all staff and witnesses potentially involved in the incident between the two residents was reviewed with the Administrator and DON throughout the survey. Based on interview and review of facility reported incident (FRI) investigation documentation it was determined the facility failed to thoroughly investigate incidents alleged physical abuse. This was evident for 3 out 12 residents (Resident #76, #122 #212) reviewed for abuse. The findings include: 1) Review of facility reported incident for Resident #76 on 07/26/2022 at 7:55 AM revealed that the resident reported that he/she received rough care from Geriatric Nursing Assistant (GNA) #40. The review of the facility's investigation did not include interviews for the other residents on the nursing unit to determine if other residents had the same complaint regarding the GNA. During an interview conducted on 07/26/2022 at 10:19 AM, the Surveyor advised the Administrator that the investigation did not include resident interviews and therefore was incomplete. The Administrator advised she would contact the case manager to see if resident interviews were conducted. However, the Surveyor was not provided documentation that resident interviews were conducted. 2) Review of facility reported incident for Resident #122 on 07/27/2022 at 8:55 AM revealed that staff witnessed Resident #83 hit Resident #122 in the face. The review of the facility's investigation did not include interviews for the other residents on the nursing unit to determine if other residents had also been hit by another resident. During an interview conducted on 07/27/2022 at 11:49 AM, the Surveyor advised the Administrator that the investigation did not include resident interviews and therefore was incomplete. The Administrator advised she would contact the case manager to see if resident interviews were conducted. However, the Surveyor was not provided documentation that resident interviews were conducted. 3) Review of facility reported incident for Resident #212 on 08/15/2022 at 8:45 AM revealed that the resident reported that he/she received rough care from Geriatric Nursing Assistant (GNA) #87. The review of the facility's investigation did not include interviews for the other residents on the nursing unit to determine if other residents had the same complaint regarding the GNA. During an interview conducted on 08/15/2022 at 9:00 AM, the Surveyor advised the Quality Assurance Director #40 that the facility's investigation did not include resident interviews and therefore was incomplete. The Quality Assurance Director stated she would see what she could find. The Surveyor was not provided documentation for resident interviews conducted.

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	215161	A. Building B. Wing	08/15/2022

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review it was determined that the facility failed to ensure a resident received appropriate respiratory care as evidenced by a resident oxygen tubing and humidifier bottle was outdated. This was found to be evident for 1 (Resident #135) out of 1 resident reviewed for respiratory. The findings include: [CONDITION(S)] ([CONDITION(S)]) is a chronic [CONDITION(S)] lung disease that causes obstructed airflow from the lungs. On 07/26/22 at 11:07 AM a tour was conducted on the B2 nursing unit. During the tour the Surveyor observed Resident #135 with a diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . During an interview conducted on 07/26/2022 at 11:08 AM the Licensed Practical Nurse (LPN) #10 stated he/she was not aware of Resident #135's outdated respiratory equipment and would replace the equipment immediately. The LPN further stated the facility's policy is to replace all oxygen tubing and humidifier bottles every 7 days. During an interview conducted on 07/26/2022 at 11:19 AM, the Director of Nursing (DON) stated Resident #135's oxygen tubing and humidifier bottle was outdated and should have been changed. The DON stated she would educate the nurse. Review of Resident #135's physician orders [MEDICAL RECORD OR PHYSICIAN ORDER] . Oxygen 2 liters /minute via nasal cannula, at all time for [CONDITION(S)]. On 07/28/2022 at 9:55 AM the DON provided the surveyor with a copy of an in-service conducted on 07/26/2022 and 07/27/2022 on labeling oxygen tubing and humidifier bottles.

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	215161	A. Building B. Wing	08/15/2022

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interviews with facility staff, it was determined that the facility failed to ensure that all employees providing direct care with residents were appropriately licensed and/or certified to care for the geriatric population. This was evident during the review of 2 of 2 employees providing 1:1 (one to one) care. A CNA (certified nursing assistant) is a person who has completed an approved nursing assistant program and has been certified as nursing assistant by the board of nursing. A GNA (geriatric nursing assistant) is a CNA who has passed the GNA state exam and is a skilled professional in providing activities of daily living (ADL i.e., bathing, dressing, toileting, feeding) care to the geriatric population. The findings include: On 07/26/22 at 8:07 AM during a tour of the 2C unit, the surveyor entered the room of Resident # 101 after knocking and observed an individual, Staff #71, who identified herself as the residents usual 1:1 staff. She stated that she was getting the resident up and dressed for the day. Resident #101 was observed sitting on the edge of the bed and Staff #71 was holding clothes in her hand. The Surveyor left the room as ADL's were in progress. Review of the medical record for Resident #101 on 7/27/2022 at 7:15 AM revealed diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . In addition, Resident #101 had an order and care plan in place for 1:1 observation initiated on 4/15/22 secondary to fall risks and related injury and remains as of 8/11/2022. On 8/7/2022 during a tour of the 2C unit at 2:30 PM, Resident #101 was observed sitting in the day room engaging with various activity mats that were available on the table in front of him/her. In addition, there was a female staff member observed standing to the right of Resident #101. The Surveyor continued a tour of the facility with observations and interviews with other residents and staff. Upon walking up the hall towards the nursing station the surveyor stopped at the day room to continue to make observations of Resident #101. The female staff member who, is now identified as Staff # 71, Resident #101's usual 1:1 was then observed acting inappropriately towards Resident #101. The Surveyor approached the staff member to get her name and noted that her badge stated, 'student.' Staff #71 stated that she was not a student that she had just graduated and was a GNA (geriatric nursing assistant). (continued on next page)

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	215161	A. Building B. Wing	08/15/2022

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The observed concerns were immediately reported to the nurse on duty. Then, was reported to the facility Administrator who arrived on the unit moments later. The Administrator immediately removed Staff #71 off the floor and took statements from her and all the staff present. The facility was notified of the concerns related to the observed abuse between the employee who identified herself as a GNA, Staff #71, towards Resident #101. Staff #71's employee file was requested by the surveyor. Upon reviewing the employees file on 8/8/2022, it was determined that she does not currently hold an active valid GNA certification. Interview occurred with the Administrator, DON and Staff Development Coordinator (Staff #35) regarding Staff #71 on 8/8/2022 at 1:09 PM regarding the observations on 8/7/2022 and her credentials. Staff # 35 stated that Staff #71 had failed her skills test and that is why she is not certified as a GNA. She is currently only given a 1:1 assignment as she is not supposed to provide direct patient care. In addition, her job title is a 'Utility Aide.' According to the facility job description, a utility aides' purpose is to 'perform non-professional direct resident care duties under the supervision of nursing personnel and to assist in maintaining a positive physical, social, psychological environment for residents.' Staff #71's work schedule was reviewed from 7/26/2022-8/8/2022 on 8/9/2022. According to the schedule and corresponding assignments, on 7/28/22 and 8/5/22, Staff #71 was given an assignment other than the 1:1. Staff #75, the Staffing Coordinator, was interviewed on 8/9/2022 at 9:12 AM. She was asked how she determines who will be assigned where. She stated that Utility Workers cannot do what GNA's do, they only watch the residents and are used mostly for 1:1's, they watch the resident and are another set of eyes, they will sit with the resident and alert staff if the resident needs anything, they are not to perform any ADL care. Staff # 75 was further asked if agency staff was aware of what Utility Workers can and cannot do and she stated 'no.' As far as communication from Staff #35 regarding Staff #71's abilities, Staff #75 stated that she was aware and notified of the 2 staff that cannot provide hands on care. At that time the survey team was made aware that there are 2 staff, not just Staff #71 that is identified as a Utility Worker. The second staff was identified as Staff # 82 who was also identified on the staffing schedule as a 1:1 for Resident #101. Staff #75 also stated that night supervisors will occasionally change the schedule after she completes it. Staff #35 intially stated that there was only one (1) Utility Worker, then later clarified that on 8/9/2022 there was another when asked about Staff #82, she stated that he had not passed his test either. Review of the medical record for Resident #101 on 8/9/2022 revealed that on the days when the Utility Aides worked with Resident #101, they documented in the electronic health record that they completed ADL care with him/her. On 8/4/2022, Staff #82 documented in Resident #101's electronic health record (EHR) that he completed bathing, dressing and toileting. Staff #71 signed off in the EHR for Resident #101 on 8/7/2022 that she completed dressing, toileting, and transfers. The Administrator addressed the survey team on 8/9/2022 at 10:34 AM and stated that the identified staff were pulled from the schedule. It was further stated that the facility staff were in the process of determining how those Utility Aides were given assignments beyond their scope for an extended period of time. These concerns were reviewed with the Administrator and the DON on 8/9/2022 at 2:38 PM. cross reference F728

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	215161	A. Building B. Wing	08/15/2022

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and review of pertinent facility documentation it was determined that the facility staff failed to obtain appropriate certification or licensure prior to working or practicing as a Geriatric Nursing Assistant (GNA), or to maintain enrollment in a Nurse Aide Training and Competency Evaluation Program (NATCEP). This was evident for 2 of 2 employees reviewed. The findings include: During the review of employee files on 8/8/2022 secondary to routine observations and facility reported incidents, it was determined that Staff #71 and Staff #82 who have the official title of Utility Aide were working and practicing as Geriatric Nursing Assistants (GNA). Interview occurred with the Administrator, DON and Staff Development Coordinator, Staff #35, regarding Staff #71 on 8/8/2022 at 1:09 PM regarding their credentials. Staff # 35 stated that Staff #71 had failed her skills test and that is why she is not certified as a GNA. She is currently only given a 1:1 assignment as she is not supposed to provide direct patient care. In addition, her job title is a 'Utility Aide.' According to the facility job description, a utility aides' purpose is to 'perform non-professional direct resident care duties under the supervision of nursing personnel and to assist in maintaining a positive physical, social, psychological environment for residents.' Staff #35 initially stated there was only 1 staff, then stated that there was another, Staff #82 and he had failed the exam, as well. Staff #71's schedule was reviewed from 7/26/2022-8/8/2022 on 8/9/2022. According to the schedule and corresponding assignments, on 7/28/22 and 8/5/22, Staff #71 was given an assignment other than the 1:1. Staff #75, the Staffing Coordinator was interviewed on 8/9/2022 at 9:12 AM. She was asked how she determines who will be assigned where. She stated that Utility Workers cannot do what GNA's do, they only watch the residents and are used mostly for 1:1 assignments, they watch the resident and are another set of eyes, they will sit with the resident and alert staff if the resident needs anything, they are not to perform any ADL care. Staff # 75 was further asked if agency staff was aware of what utility workers can and cannot do and she stated, 'No.' As far as communication from Staff #35 regarding Staff #71's abilities, Staff #75 stated that she was aware and notified of the 2 staff that cannot provide hands on care. At that time the survey team was made aware that there are 2 staff, not just Staff #71 that is identified as a Utility Worker. The second staff was identified as Staff # 82 who was also identified on the staffing schedule as an one to one (1:1) for Resident #101. Staff #75 also stated that night Supervisors will occasionally change the schedule after she completes it. Review of the medical record for Resident #101 on 8/9/2022 revealed that on days the Utility Aides worked with Resident #101, they documented in the electronic health record that they completed ADL care with him/her. On 8/4/2022 Staff #82 documented in Resident #101's electronic health record (EHR) that he completed bathing, dressing and toileting, Staff #71 signed off in the EHR for Resident #101 on 8/7/2022 that she completed dressing, toileting, and transfers. The Administrator addressed the survey team on 8/9/2022 at 10:34 AM and stated that the identified staff were pulled from the schedule, and they are in the process of determining how they were given assignments and how those individuals determined they could work beyond their scope. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cross reference F725

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview with facility staff, it was determined that during the readmission of a resident the facility staff failed to acquire the appropriate new medication orders and therefore ordered and administered medications from the resident's hospital admission. This was evident during the review of a facility reported incident and 1 of 3 readmissions. Resident (#83) The findings include: Review of the closed medical record on 8/1/2022 at 1:24 PM for Resident #83 revealed a readmission to the facility on [DATE]. This readmission was post hospitalization for chronic [CONDITION(S)] (a condition that results in the inability to effectively exchange carbon [MEDICATION(S)] and oxygen) and chronic heart failure with preserved ejection fraction (the heart pumps normally but is too stiff to fill properly). During the resident's hospital stay s/he was given intravenous (IV) antibiotics for pneumonia (an infection that inflames the air sacs in one or both lungs) that were to continue at the facility orally (by mouth) as the IV was discontinued in the hospital prior to the resident's arrival at the facility. In addition, Resident #83 was to have 'close outpatient follow-up by cardiology.' Upon the resident's arrival at the facility on 9/18/2019 at 2:00 AM, according to the facility report, the Charge Nurse failed to obtain the discharge summary from the hospital and instead used the hospital medication administration report to review medications with the provider on-call and transcribe the orders which resulted in multiple medication errors. Interview on 8/8/2022 at 11:55 AM with Unit Manager Licensed Practical Nurse (LPN #46) revealed that Resident #83 was readmitted on a Sunday. When she came in on Monday, she acquired the discharge summary from the hospital and discovered there were multiple medication discrepancies. She contacted the facility Nurse Practitioner, and an assessment was completed on the resident as well as a correction to his/her medications. The following medications were ordered and administered in error according to staff LPN #46; the facility had the resident consent to an unnecessary peripherally inserted central catheter (PICC) line for the antibiotics to be administered via the central line, [MEDICATION(S)] (a diuretic) 40 mg twice a day, losartan for hypertension and [MEDICATION(S)] for [CONDITION(S)]. The discontinued medications were initially ordered related to the resident's cardiac status, however that changed in the hospital, and they were no longer to be administered. The medications were discontinued secondary to [CONDITION(S)] (low blood pressure) and orthostatic (low blood pressure in the upright position). The findings and concerns were reviewed with the Director of Nursing (DON) and Administrator throughout the survey and again on 8/11/2022.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of medical record documentation, it was determined that the facility failed to: 1) maintain a safe and effective system for securing medication, treatment supplies, and hazardous medical equipment in their designated carts on nursing units with confused and wandering residents. This practice was noted over three days (7/25/2022-7/27/2022) and included six instances where medication/treatment carts were observed unlocked and unattended. Unsecured carts were noted on 3 of the 6 nursing units. Additionally, the facility failed to: 2) ensure that a resident was assessed for being able to self administer medication. This was evident for 1 (Resident #78) of 1 resident reviewed for medication self administration. The Maryland Office of Health Care Quality (OHCQ) determined that this concern met the Federal definition of Immediate Jeopardy and the facility was provided verbal and written notification of this determination at 1:10 PM on 07/27/2022. The date of compliance was 07/27/2022. The findings include: 1) a. During an initial tour and observation of Nursing Unit C3 on 7/25/2022 at 10:33 AM a treatment cart was observed unlocked. The Surveyor was able to open all the drawers of the cart and observed a 23 gauge ' BD ' brand vacutainer needle used for blood draws in the top drawer. Resident # 28, who was identified as a ' wanderer ' by the Unit Manager #7, was also observed walking independently up and down all the halls of the nursing unit at that time. The Unit Manager #7 saw this Surveyor at the cart, came over and locked it. b. On 7/26/2022 at 11:01 AM on a subsequent tour of Nursing Unit C3, the same treatment cart, in the same location was observed unlocked. This surveyor saw the same items accessible including the 23-gauge needle in the top drawer as well as several other prescription creams for 6 other residents and other lotions and cleansers for wound care. Residents #28 and #64 were noted to be wandering the unit. The Surveyor notified the Unit Manager #7 at 11:06 AM. A record review was conducted on 7/26/22 at 11:30 AM. The review revealed that Resident #28 ' s most recent Brief Interview of Mental Status (BIMS) assessment, conducted on 7/17/22, coded the resident with a BIMS of 3/15, representing severe cognitive impairment. The review also revealed that Resident #64 's most recent BIMS assessment, conducted on 5/10/22, coded the resident with a BIMS of 11/15, representing moderate cognitive impairment. Resident #64 was also noted to have an order dated 5/11/22 that stated to keep safety device boxes out of reach of residents. c. During a tour conducted on the B2 nursing unit on 07/26/2022 at 2:15 PM, the Surveyor observed an unattended and unlocked medication cart. The Surveyor was able to open each drawer of the medication cart. Each drawer had medications that were labeled with Residents' names and room numbers. The Surveyor observed the Charge Nurse #11 walk from out of the hallway of B201 and go to the nurses' station. The Surveyor asked the Unit Clerk #8 who the medication cart belonged to; the Unit Clerk stated the cart belonged to Charge Nurse #11. (continued on next page)

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	215161	A. Building B. Wing	08/15/2022

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an Interview conducted on 07/26/2022 at 2:19 PM, the Charge Nurse #11 stated she had an emergency and did not lock her cart. The surveyor observed the Charge Nurse lock the medication cart. d. During a tour of Nursing Unit B3 on 7/26/2022 at 2:50 PM, the Surveyor observed a medication cart located at the nurses' station unlocked. The Surveyor observed the cart for 2 minutes until Licensed Practical Nurse (LPN) #9 walked up to the cart. The Surveyor asked if this medication cart was his and he stated, yes. The Surveyor asked where he was, and LPN #9 stated that he was down the hall in a resident ' s room. LPN #9 confirmed that this was his cart and that it was unlocked. On 07/26/2022 at 3:16 PM the Administrator and the Director of Nursing (DON) were informed of the multiple observations and corresponding concerns related to the observed open medication and treatment carts, in addition to the concern that one of the observed carts was observed multiple times on the same unit with an active known wanderer. e. On 7/27/2022 at 6:12 AM, the Surveyor toured Nursing Unit C3. Down the 300 hallway a medication cart was observed from the nurses' station angled out in the middle of the hallway by room later identified as room [ROOM NUMBER]. As the Surveyor approached the cart it was noted to be unlocked with used medication wrappers on top. LPN #10 exited from room [ROOM NUMBER] and asked if the cart was in [MEDICATION(S)] and proceeded to move the cart and turn it towards herself as the cart was open and angled towards the room across the hall. This Surveyor verified that it was indeed her cart and that it was unlocked, in the middle of the hall and out of her sight. The LPN stated yes, however, ' the treatment cart is locked, and I cannot access it. ' f. During a tour conducted on 07/27/2022 at 6:10 AM on the B2 nursing unit, the surveyor observed 1 medication cart and 1 treatment cart unattended and unlocked located at the nurses' station. The Surveyor was able to open each medication drawer that had labeled medications with the resident's name and room number. The Surveyor observed a nurse down the hallway standing at another medication cart. During an interview conducted on 07/27/2022 at 6:12 AM, LPN #12 stated he was aware the medication and treatment carts were unlocked. The LPN stated he did not recall the codes to each cart and was fearful that if he locked the carts, he would not be able to unlock the cart again. The LPN called another LPN #13 from a different nursing unit to retrieve the code for the carts. The surveyor observed the LPN lock each cart. The facility provided a plan to remove the immediacy while the surveyors were onsite. The removal plan was accepted by the OHCQ at 6:40 P.M. on 07/27/2022. The plan included the following provisions: - The DON immediately conducted an audit of all medication and treatment carts to ensure all locks were functional - Unit Managers evaluated Residents #28 and #64 to ensure neither resident experienced a negative outcome related to the deficient practice. - The DON or designee completed education with nurses and CMAs on duty, then provided education to all other nurses and CMAs upon arrival prior to beginning their next shift. Any nurse or CMA failing to receive this training will be removed from the schedule. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlotte Hall Veterans Home	29449 Charlotte Hall Road Charlotte Hall, MD 20622

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Beginning on 07/27/2022 at 1:20 PM, administrative staff were assigned to provide active monitoring of medication and treatment carts until education of all active staff was completed and staff provide verbal acknowledgement of education. - Supervisors were trained by the DON to remain on educating oncoming staff and then providing at least one audit of medication and treatment carts per shift. - Audits will continue on each unit during each shift for three days, then weekly for four weeks, then monthly for two months. These audits will be turned in to the DON and it will be reported to the Quality Assurance committee to ensure continued compliance. - This education was added to the facility orientation for agency nurses / CMAs by the Staff Development Coordinator. On 08/08/2022 the Surveyors determined that the facility met the removal plan requirements and deemed the compliance date 07/27/2022. 2) During an interview conducted on 07/27/22 at 10:03 AM, Resident #78 stated he had an indwelling catheter that was painful, but he/she had a medication that was self-administered that helped with his/her pain. The resident showed the Surveyor a medication bottle that was opaque in color with a white top. The medication label stated [MEDICATION(S)] topical solution USP viscous 2%. A review of Resident # 78 Medication Administration Record [MEDICAL RECORD OR PHYSICIAN ORDER] . Apply to tip of penis/catheter insertion site every 8 hours as needed for pain. A review of the physician orders [MEDICAL RECORD OR PHYSICIAN ORDER] . During an interview conducted on 08/05/2022, at 8:30 AM, the Surveyor advised the Director of Nursing (DON) of the findings and concerns. During an interview conducted on 08/05/222 at 9:15 AM, the Unit Manager #46 stated she was not aware Resident #78 had the medication [MEDICATION(S)] 2% Viscous Soln in his/her room and had self-administered the medication. On 08/08/2022 at 10:37 AM the DON provided the Surveyor a copy of the in-service conducted for self-administration of medications, procedures for assessing residents to determine if the resident can self-administer their medication, and medication storage. On 08/11/2022 at 10:32 AM, the Unit Manager #46 provided the Surveyor with a copy of the progress note that stated Late entry 08/05/2022- pain assessment completed on this date. [Physician name] notified of findings. Verbal order given to d/c [discontinue] prn [as needed] [MEDICATION(S)] 2% and to start [MEDICATION(S)] 2% viscous soln to tip of penis every 8 hours routine if patient agrees. Resident aware and in agreeance with orders and verbalized consent for nursing staff to administer medication as ordered. The Unit Manager also provided the Surveyor with an assessment for Resident #78 for self- administration of Medication conducted on 08/05/2022.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview with residents and facility staff, it was determined that the facility failed to ensure that food was delivered to residents at an appropriate and palatable temperature. This was evident for 1 out of 1 observation of test tray temperatures. This practice has the potential to affect all residents who eat food prepared by the facility. The findings include: On 7/26/22 at 9:16 AM, the surveyor interviewed Resident #7 who resided on the 3A unit. During the interview, the resident stated that food that is supposed to be warm is always cold by the time s/he receives his/her tray. On 7/27/22 at 11:29 AM, the surveyor interviewed Resident #21 who also resided on the 3A unit. During the interview, this resident also stated that food that is supposed to be warm is always cold by the time s/he receives his/her tray. The surveyor conducted a breakfast test tray observation that began on 7/29/22 at 7:20 AM. A test tray was requested by the surveyor to be included on the cart going to the 3A unit. During the observation, the surveyor noted that plate pellets that were designed to hold heat and keep plates warm were being prewarmed by an induction heater and then stacked prior to being plated rather than being plated immediately after warming. More than 20 pellets were being stacked in this manner. The stacks were beside the steam tray in open air. Nothing prevented the stacked pellets from cooling in the ambient air prior to being used in tray line. The Food Service Compliance Officer (Staff #27) was interviewed at 7:49 AM during the test tray observation. During the interview, the Food Service Compliance Officer stated that she had come into the role recently and was planning to change the way that the pellets were being prepared, that the pellets were no longer to be stacked in the manner described above. Instead, each one should be warmed at the time that it was to be plated to minimize how much the base cooled prior to being served to residents. The Compliance Officer confirmed that this new practice hadn't been implemented yet. The first tray was placed in the cart for the unit at 7:21 AM. The surveyor's test tray was prepared at 7:24 AM. The last tray destined for 3A was placed in the cart at 7:31 AM. The cart arrived on the unit at 7:38 AM. The first tray was removed from the cart by staff on the unit at 7:49 AM. Only one staff person was delivering trays at that time. Two additional staff persons began assisting with tray delivery at 7:57 AM, and a fourth staff person joined them at 8:00 AM. The final tray was delivered on the unit at 8:08 AM, 30 minutes after the cart had arrived to the unit. The test tray temperatures were tested at that time in the presence of the Food Service Compliance Officer (Staff #27). The temperatures were: oatmeal, 117 F; milk, 60 F; orange juice, 70 F; scrambled eggs, 108 F; and bacon, 100 F. The surveyor interviewed the Food Service Compliance Officer at the end of the test tray process, around 8:10 AM, who stated that her expectation for trays delivered to units was that hot foods were maintained at a temperature of 120 F or higher and cold foods were maintained at a temperature of 42 F or colder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor interviewed the Administrator on 7/29/22 at 12:16 PM. During the interview, the Administrator stated that several changes had been implemented in the kitchen after the tray line observation. She stated that juice was now being kept in a cooler in the kitchen instead of placed in a container in tray line, with the goal of keeping the juice colder for longer. The Administrator also said that kitchen staff were educated on the process for warming plate pellets, stating that they should be warmed and used one at a time rather than warmed and stacked.

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	215161	A. Building B. Wing	08/15/2022

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on interviews and record reviews it was determined the facility failed to ensure that staff acknowledged a food allergy for a resident. This was found to be evident for 1 (Resident #147) out of 1 Resident reviewed for allergies. The findings include: During an interview conducted on 07/26/22 at 11:35 AM, Resident#147 stated he/she had an allergy to shrimp but is given shrimp regularly although his/her meal tray card stated allergy to shrimp. The Resident stated that he only ate the vegetables when shrimp was served to him/her on many occasions. The resident further stated he/she had told multiple staff on the nursing unit but continued to receive shrimp as his/her entree. On 07/26/2022 12:59 PM an interview was conducted with the Food Service Compliance Officer #27. The Food Service Compliance Officer #27 stated the Unit Manager or Registered Dietician (RD)emailed residents' food allergies and preferences to dietary. Dietary would input the allergy or preference into the RDS tray system which would automatically update the tray cards to show the food allergy or food preference. The Food Service Compliance Officer provided the Surveyor Resident #147's tray card that showed the resident had an allergy to shrimp and further stated the allergy alerts the staff to provide a substitute meal. On 08/05/2022 at 12:20 PM an interview conducted with Resident#147 who stated he/she was served shrimp poppers for lunch on 08/04/2022. The Resident stated he/she advised Licensed Practical Nurse (LPN) #24. During an interview conducted on 08/05/2022 at 12:25 PM, LPN #24 stated Resident #147 showed her the resident's meal tray that had shrimp poppers and the meal tray card that stated allergy to shrimp. The LPN further stated she called the kitchen and confirmed the entree was shrimp poppers, she then notified the Nurse Educator #35. The Nurse Educator took Resident #147's meal tray to the kitchen and brought back a sandwich and onion rings. During an interview on 08/05/2022 at 12:45 PM the Surveyor advised the Administrator of the findings and concerns. On 08/05/2022 at 1:00 PM the Nursing Home Administrator provided an in-service conducted in the kitchen for food allergies.

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	215161	A. Building B. Wing	08/15/2022

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation and interview with facility staff, it was determined that the facility failed to conduct routine surveillance and maintenance to assure that their pest control program was adequately maintained. This practice had the potential to affect all residents. The findings include: Throughout the survey, surveyors noted small flying insects present in common areas of the facility and in some resident rooms. The insects were primarily the size of gnats, but several flies were also seen. During an observation that took place on 7/26/22 at 11:12 AM, the surveyor noted flies in Resident #129's room. The resident was interviewed at that time and stated that s/he would frequently see flies in and out of his/her room and that they are unpleasant. During an observation that took place on 7/26/22 at 1:39 PM, the surveyor noted a fly in Resident #9's room. The resident was interviewed at that time and also complained of flies in the room, specifically stating that they land on his/her food when s/he is trying to eat. The surveyor interviewed the Assistant Director of Maintenance on 8/10/22 at 10:38 AM. During the interview, the Assistant Director discussed the facility's established methods of pest control as part of their pest control plan. The plan included an air curtain device that created outward air flow at certain entrances to prevent flying insects from entering the facility. The Assistant Director specified that one of the air curtains was over by the loading docks for the kitchen. The surveyor conducted an observation of the kitchen exits with the Assistant Director on 8/10/22 at 11:06 AM. During the observation, it was noted that the air curtain at the exterior door to the dumpsters was not operating - it did not activate when the door opened. The Administrator was notified of the malfunctioning air curtain on 8/10/22 at 11:10 PM.

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	215161	A. Building B. Wing	08/15/2022

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility investigative material, it was determined that facility staff failed to change a resident when needed. This is evident for 1 (Resident # 222) out of 59 residents reviewed for facility reported incidents. The findings include: A medical record review and incident report for abuse was conducted on 8/11/22 at 8:15 AM. The review revealed that Resident #222 was admitted to this facility in November 2018. His/her diagnoses included muscle spasms, reduced mobility, stroke, and [CONDITION(S)] stage 3. The resident also suffers from [CONDITION(S)], anxiety and has a care plan for making false accusations against staff. On 4/14/19 at 11:15 PM, Resident #222 accused staff of being verbally abusive and rude. The resident stated that Geriatric Nursing Assistant (GNA) #83 threw his/her clothes on the wheelchair in his/her room and held up a diaper where s/he could see it and stated this diaper is not wet. Resident #222 stated that the diaper was soaking wet. The resident also stated that the GNA said to him/her that s/he was abusive with the call light and stated, that is why your family doesn't want to take care of you. Review of resident records and interviews obtained by staff investigating the alleged incident revealed that, on 4/14/19, GNA #83 worked on the 3-11 PM shift and was assigned to Resident #222. At 4:15 PM, Resident #222 used his/her call bell and asked to be changed. GNA #83 responded, ok, and changed his/her diaper. The GNA also stated that the next diaper change time would be at 6:15 PM. Resident #222 responded, OK. The GNA then went to other rooms to take care of other residents. During that time, Resident #222 rang the call bell again and other GNAs responded. At 6:15 PM, GNA #83 went into Resident #222's room and changed him and told him the next change would be at 8:15 PM. The record review revealed that later, another GNA came and told GNA #83 that she changed Resident #222 at 7:15 PM. GNA #83 said to the other GNA that its not time to change him. He should be changed at 8:15 PM and to tell Resident #222 that since he got changed early his next change will be at 10:15 PM. At 9:00 PM, GNA #83 took her break and was sitting in the day room when Resident #222's call bell went off. GNA #83 and another GNA got up from the break room and entered Resident #222's room. Resident #222 stated s/he needed to be changed. Record review revealed further that GNA #83 told Resident #222 that it was not time to be changed and the next scheduled time for him/her to be changed would be at 10:15 PM. Both GNAs left the room. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlotte Hall Veterans Home	29449 Charlotte Hall Road Charlotte Hall, MD 20622

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The administrative team was made aware of this dignity issue on 8/11/22. GNA #83 was inserviced for Resident Rights when she returned to work after being suspended.

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	215161	A. Building B. Wing	08/15/2022

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Charlotte Hall Veterans Home	29449 Charlotte Hall Road Charlotte Hall, MD 20622

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident record review, and staff and resident interviews, it was determined that the facility failed to: 1) ensure that residents were free from abuse (Resident #17); 2) ensure that residents were free from neglect (Resident #10); 3) maintain adequate supervision of residents with documented histories of aggressive behavior with care planned interventions in place including to perform routine checks to prevent potential 'inappropriate,' and 'aggressive' behavior (Resident #187); and 4) prevent abuse occuring from an employee towards a resident (Resident #235). This was found to be evident for 4 out of 49 residents reviewed for abuse and neglect. As a result of this failure, actual harm was identified for Resident #17. The findings include: 1) A review of the nurse's notes for Resident #17 was conducted on 08/09/2022 at 9:00 AM. The nurses note stated on 05/27/2022 at approximately 4:20 PM the Unit Manager # 42 was told by Resident #17 and his/her roommate Resident # 148 that Geriatric Nursing Assistant (GNA) #74 bent Resident #17's right thumb back. The Unit Manager #42 assessed the resident's right thumb and concluded the thumb appeared abnormal. A physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . A review of the hospital discharge summary on 08/09/2022 at 9:10 AM revealed Resident #17 was diagnosed with a dislocation of the right thumb in 05/27/2022. BIMS stands for Brief Interview for Mental Status. The BIMS test is used to get a quick snapshot of how well you are functioning cognitively at the moment. It is a required screening tool used in nursing homes to assess cognition. The resident can score 0 to 15 points on the test. A score of 13 to 15 suggests the patient is cognitively intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment. During an interview conducted on 08/09/2022 at 9:25 AM, Resident #17 with a Brief Interview of Mental Status (BIMS) of 8 stated GNA # 74 came into the resident's room and questioned what he/she was doing with the pillows. The resident stated he/she wanted to have someone to put his pillows in the closet. According to the resident, the GNA began to yell at him/her because the resident did not want the pillows on the bed. The resident further stated the GNA was very mad and grabbed the resident's right thumb, twisted, and pulled his/her thumb back. During an interview conducted on 08/09/2022 at 9:32 AM, Resident #148 (Resident #17's roommate) with a BIMS of 15 stated he /she witnessed GNA #74 yell at Resident#17 and bend the resident's right thumb all the way back. An interview conducted on 08/09/2022 at 10:27 AM, the Unit Manager #42 stated she was told by Resident #17 and Resident #148 on 05/27/2022 that GNA #74 bent Resident #17's right thumb back. The Unit Manager stated she assessed the resident's thumb, obtained a physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . (continued on next page)

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	215161	A. Building B. Wing	08/15/2022

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Charlotte Hall Veterans Home	29449 Charlotte Hall Road Charlotte Hall, MD 20622

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview conducted on 08/10/2022, the Administrator stated GNA #74 was suspended on 05/27/2022 pending an investigation and terminated as result of the facility's investigation. On 08/09/2022 a review of the facility's investigation confirmed the facility suspended GNA #74 pending the facility's investigation and then terminated the GNA based on the results of the investigation. The facility reported the GNA to the Board of Nursing for the abuse of the resident. 2) During an interview conducted on 07/25/2022 at 10:00 AM, Resident #10 stated he/she was left alone in the whirlpool bathtub by GNA #88. The resident stated he/she was fearful that he/she would have slid under the water because of his/her lack of muscle strength. The resident stated he/she yelled for help, the staff came and removed him/her from the whirlpool bathtub. The surveyor asked if the resident had slid under the water, the resident stated no; the resident was asked if he/she received whirlpool baths since the incident, the resident stated no and that he/she never liked a whirlpool bath. The resident further stated the incident did not cause him/her to be fearful of a whirlpool bath or any other type of bath. An interview conducted on 07/25/2022 at 10:22 AM, the Unit Secretary #8 stated she was present at the time of the incident. The Unit Secretary stated the resident is a transfer by Hoyer lift. On the day of the incident the GNA [NAME] the resident to the whirlpool bath in his/her wheelchair. The GNA Hoyer lifted the resident out of the wheelchair and into the whirlpool bathtub. The resident remained on the Hoyer lift with the Hoyer lift pads under him/her. The GNA#88 left Resident #10 inside the whirlpool bathtub on the Hoyer lift. Several minutes later the resident yelled for help and several staff ran into the whirlpool bathtub room. The resident was Hoyer lifted out of the whirlpool and assessed. [CONDITION(S)] is a genetic condition that affects the nervous system and causes movement problems. People with this condition develop impaired muscle coordination (ataxia) that worsens over time. Other features of this condition include the gradual loss of strength and sensation in the arms and legs; muscle stiffness ([CONDITION(S)]); and impaired speech, hearing, and vision. On 07/25/2022 at 1:27 PM a review of the Resident #10's medical record revealed the resident had a diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . On 07/29/2022 at 1:22 PM a review of the facility's investigation revealed the facility suspended GNA #88 pending the investigation on the day of the incident 03/15/2022. After viewing camera footage, the facility determined GNA #88 left Resident #10 in the whirlpool bathtub for 8 minutes and the GNA was immediately terminated. On 08/01/2022 at 7:15 AM review of Resident #10's Psychiatric note dated 03/16/2022 stated resident anxious and tearful following being left in the whirlpool bath for an extended period of time. On 08/01/2022 at 7:16 AM review of Resident #10's psychiatric note 03/24/2022 stated/noted the resident was back to baseline and stated/noted that he was doing fine. Resident stated he wishes to get showers instead of baths. (continued on next page)

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	215161	A. Building B. Wing	08/15/2022

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 08/01/2022 at 10:50 AM the Surveyor advised the Administrator of the concern. The Administrator stated she recalled the incident. The Administrator stated that GNA #88 was first suspended immediately and after viewing the camera footage the GNA was immediately terminated. The facility immediately conducted bathtub safety in-services, and competency for mechanical lift and the resident's physician placed a new order for a shower chair and 2 caregiver assistants. On 08/01/2022 at 1:00 PM the Administrator provided the Surveyor with supportive documentation of the interventions implemented. Based on medical record review, interview, and observation of residents, it was determined that the facility failed to: 1. maintain adequate supervision of residents with documented histories of aggressive behavior with care planned interventions in place including to perform routine checks to prevent potential 'inappropriate,' and 'aggressive' behavior and 2. failed to prevent abuse occuring from an employee towards a resident. This was evident during the review of an abuse allegation between 2 residents (#187 and #235) and observations during tour. The findings include: 3) Surveyor reviewed the facility reported investigation into the resident-to-resident altercation between Resident #187 and #235 on 8/2/2022 at 7:25 AM that occurred on 5/26/2021. The report documented that the Charge Nurse, staff #18, was alerted to an altercation between 2 residents by another resident. Staff #18 responded and observed Resident #235 'stomping' on the head of Resident #187. The residents were separated, and Resident #187 was sent to the hospital for evaluation. Review of Resident #187 and #235 care plans both included interventions related to a history of aggressive behaviors documented towards staff and other residents requiring routine checks and monitoring, however, no staff were aware of either residents' status at the time of the incident according to the interviews provided in the facility investigation. Review of the medical record on 8/2/2022 at 7:34 AM for Resident #187 revealed diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . Additionally, on 10/10/2019 a care plan was initiated for aggressive behavior towards staff, this was reviewed as recent as 4/19/2021 and remained active at the time of the altercation. Resident #185's Brief Interview for Mental Status (BIMS 15-point cognitive screening measure that evaluates memory and orientation) at the time of the incident was not completed, the score was '99' as the resident was not a candidate cognitively to complete the exam. Review of the medical record for Resident #235 revealed diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Care plans reviewed revealed identified problems and goals in place from 3/17/2020 regarding numerous behavior problems such as aggression and territorial behavior with approaches including to perform routine checks on the resident. Social services assessed Resident #235 after the incident that occurred on 5/26/2021 on 5/27/2021 and determined that s/he had a BIMS score of 6/15 meaning that s/he had 'severe impairment' in cognitive functioning. Interview on 8/11/2022 at 9:05 AM with staff #15, the Regional Nurse Consultant, regarding what 'routine checks' was revealed the expectation was that staff would complete their usual 2-hour checks on the residents. In addition, their behaviors, if any, are documented every shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. Building B. Wing	08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlotte Hall Veterans Home	29449 Charlotte Hall Road Charlotte Hall, MD 20622

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Regarding Resident #235, on the day of the incident 5/26/2021 at 10:02 AM, staff documented that s/he had exhibited behaviors and rejection of care. There was no additional documentation of monitoring, observations or interventions related to the already documented behaviors exhibited by Resident #235 on the afternoon of 5/26/2021 prior to him/her inflicting aggression on Resident #187 that led to his/her hospitalization . These findings and concerns were reviewed with the facility DON and Administrator throughout the survey and again on 8/11/2022. Cross reference with F610 4) On 8/7/2022 during a tour of the 2C unit at 2:30 PM, Resident #101 was observed sitting in the day room engaging with various activity mats that were available on the table in front of him/her. A female staff member was observed standing to the right of Resident #101. Surveyor continued tour of the facility with observations and interviews with other residents and staff. Upon walking up the hall towards the nursing station surveyor stopped at the day room to continue to make observations of Resident #101. The female staff member who is now identified as staff # 71 and also Resident #101's usual 1:1 was then observed aggressively pulling Resident #101 up in the chair by the residents' right arm, then threw the residents' right arm across his/her body and angrily stated 'stop that.' She then looked around and saw the Surveyor watching her. Surveyor approached the staff member to get her name and noted that her badge stated 'student.' Staff #71 stated that she was not a student that she had just graduated. The observed concerns were immediately reported to the nurse on duty, LPN staff #68 , then the facility Administrator who happened on the unit moments later. The Administrator immediately removed Staff #71 off the floor and took statements from her and all the staff present. The facility was notified of the concerns related to the observed abuse and inappropriate interaction between the employee who identified herself as a GNA, staff #71 towards Resident #101.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on record review, interview, and review of pertinent facility documents and policies, it was determined that the facility failed to thoroughly investigate an allegation of abuse. This was evident for * of * facility reported incidents reviewed. The findings include: Surveyor reviewed the facility reported investigation into the resident-to-resident altercation between Resident #187 and #235 on 8/2/2022 at 7:25 AM that occurred on 5/26/2021. The report documented that the Charge nurse, staff #18 was alerted to an altercation between 2 residents by another resident. According to Staff #18's statement he immediately responded and separated the two residents. Further review of the facility's' investigation failed to reveal the assignment schedule, which staff was assigned to which resident, in the investigation packet. According to the interviews in the packet no one observed anything until they were notified later that there was an 'incident.' The actual staff caring for the two residents were not identified, neither was the resident that alerted the Charge nurse of the incident. Review of Resident #187 and #235 care plans both included interventions related to behaviors needing routine checks and monitoring, however, no staff were aware of either residents' status or whereabouts at the time of the incident according to the statements provided in the facility investigation. On 8/3/2022 at 10:03 AM Surveyor requested the actual schedule for 5/26/2021 from the Director of nursing (DON) to determine if all staff was interviewed and who was assigned to the two residents. On 8/4/2022 at 7:08 AM the DON reported that she did not have the schedule, however, was able to see who documented on the residents and is contacting the employees now for statements but further stated that yes, there are no statements in the packet from those 2 identified employees that were on the schedule. The surveyor also reviewed with the DON that a statement regarding the incident was not requested from the resident that alerted the Charge nurse to the altercation. Surveyor reviewed the census for that unit on 8/3/2022 at 12:30PM. This review revealed that there were at least 3 residents residing on the unit at the time of the incident with a brief interview for mental status (BIMS 15-point cognitive screening measure that evaluates memory and orientation) over 10, showing they were only moderately impaired with one individual scoring a 13-meaning s/he was cognitively intact. Quality assurance staff #44 wanted to present her findings and investigation to the survey team on 8/11/2022 at 12:20 PM. She stated that she felt the investigation was thorough as she saw everything on video. She stated that no one was around, Resident #235 went after Resident #187, and she felt there was nothing further needed in the investigation that was provided. The concern that the survey team had requested any contributory investigative information for 2 weeks related to our identified concerns and nothing further was provided was reviewed with her at this time, in addition to the new concern that her findings related to the video was not in the investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #235 had documented behaviors prior to the incident on the morning or 5/26/2021. Nothing related to this or interviews from his/her assigned staff was in the investigation or determination as to why witnesses (the resident who alerted the charge nurse) or other residents and staff were not interviewed regarding the incident. Completion of a thorough investigation allows a facility to implement timely and appropriate interventions for the safety of all involved. The concern that the facility failed to do a thorough investigation, including interviewing all staff and witnesses potentially involved in the incident between the two residents was reviewed with the Administrator and DON throughout the survey. Based on interview and review of facility reported incident (FRI) investigation documentation it was determined the facility failed to thoroughly investigate incidents alleged physical abuse. This was evident for 3 out 12 residents (Resident #76, #122 #212) reviewed for abuse. The findings include: 1) Review of facility reported incident for Resident #76 on 07/26/2022 at 7:55 AM revealed that the resident reported that he/she received rough care from Geriatric Nursing Assistant (GNA) #40. The review of the facility's investigation did not include interviews for the other residents on the nursing unit to determine if other residents had the same complaint regarding the GNA. During an interview conducted on 07/26/2022 at 10:19 AM, the Surveyor advised the Administrator that the investigation did not include resident interviews and therefore was incomplete. The Administrator advised she would contact the case manager to see if resident interviews were conducted. However, the Surveyor was not provided documentation that resident interviews were conducted. 2) Review of facility reported incident for Resident #122 on 07/27/2022 at 8:55 AM revealed that staff witnessed Resident #83 hit Resident #122 in the face. The review of the facility's investigation did not include interviews for the other residents on the nursing unit to determine if other residents had also been hit by another resident. During an interview conducted on 07/27/2022 at 11:49 AM, the Surveyor advised the Administrator that the investigation did not include resident interviews and therefore was incomplete. The Administrator advised she would contact the case manager to see if resident interviews were conducted. However, the Surveyor was not provided documentation that resident interviews were conducted. 3) Review of facility reported incident for Resident #212 on 08/15/2022 at 8:45 AM revealed that the resident reported that he/she received rough care from Geriatric Nursing Assistant (GNA) #87. The review of the facility's investigation did not include interviews for the other residents on the nursing unit to determine if other residents had the same complaint regarding the GNA. During an interview conducted on 08/15/2022 at 9:00 AM, the Surveyor advised the Quality Assurance Director #40 that the facility's investigation did not include resident interviews and therefore was incomplete. The Quality Assurance Director stated she would see what she could find. The Surveyor was not provided documentation for resident interviews conducted.