State-Owned Nursing Homes

Health-General Article §19-14C-02(b)

Maryland Department of Health
Office of Health Care Quality

January 2026

On behalf of the Maryland Secretary of Health, the Office of Health Care Quality (OHCQ) issues state licenses that authorize the operation of certain health care facilities or programs in Maryland, such as nursing homes. The state licensure requirements establish the minimum health and safety requirements to obtain and maintain a license to operate in Maryland.

OHCQ reports that there is only one State-owned nursing home, Charlotte Hall Veterans Home (CHVH), that is operated by a contractor and is overseen by the Maryland Department of Veterans and Military Families (MDVMF). CHVH is located in St. Mary's County and is licensed by OHCQ.

During the 12-month time frame preceding this report, November 1, 2024, to November 1, 2025, OHCQ conducted the following surveys:

- April 4, 2025 - Complaint survey
- June 13, 2025 - Revisit survey
- July 25, 2025 - Annual/Recertification Health survey
- August 26, 2025 - Life Safety Code Recertification survey

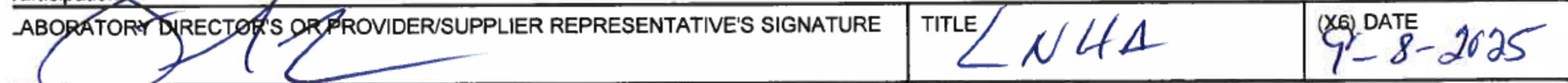
The Statements of Deficiencies and the Provider Plans of Correction are attached to this report. Based upon the April 4, 2025, complaint survey, OHCQ issued a civil money penalty of $5,000 and the Centers for Medicare and Medicaid Services (CMS) issued a civil money penalty of $100,880 to CHVH. OHCQ has not issued any other enforcement actions to CHVH during this same time frame.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **215161**	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 0...** B. WING	(X3) DATE SURVEY COMPLETED **08/26/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlotte Hall Veterans Home	**29449 CHARLOTTE HALL ROAD , CHARLOTTE HALL, Maryland, 20622**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	INITIAL COMMENTS The following deficiencies are the result of a Life Safety Code recertification survey conducted on August 26, 2025, between 10:45 a.m. and 4:15 p.m. at your facility for the purpose of determining compliance with Medicare & Medicaid requirements by a Fire and Life Safety Code surveyor from MDH-OHCQ. This facility occupies a three-story Type II constructed facility. The SNF portions are identified as the A, B & C wings as well as the "Core". It does not have an attic. There is interstitial space between some Areas of the 3rd floor and the roof which contains no storage or mechanical equipment and the Type II construction is maintained. It has a partial basement. It is fully automatic sprinkler protected. Survey activities include observation of the physical environment, review of facility records, observation of staff practices, and interviews with staff members.	K0000	K211 A. The exterior automatic sliding doors in the dining room feature a single-cylinder keyed lock (from the exterior) and a ¼ turn thumb knob on the interior and are labeled "in an emergency push to open". The lock was removed from the door and blank tumbler placed, to correct this deficiency on 9/8/2025. No residents were affected. B. All exit discharges with means of egress were immediately inspected and the dining room sliding doors is part of the facility maintenance program. Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full instant use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. No residents were affected. C. Root cause analysis determined the facility failing to maintain an unobstructed means of egress has the potential to cause harm to 50% of the occupants in the facility. If these became locked there are no features to ensure unrestricted access in the event of a fire or similar emergency as required by NFPA 101:7.2.1.5.1, 19.2.2.2.4. No residents were affected. Education will be given to the Assistant Administrator, Maintenance Director & Director of Safety & Security by the Administrator on September 8, 2025. D. The Maintenance Director/Assistant and Director of Safety & Security will conduct daily audits to ensure that unobstructed means of egress is continuously maintained. The audits will be conducted once daily until 100% compliance is achieved for 5 consecutive days. Random audits will continue once weekly until 100% compliance is achieved for 4 consecutive weeks, then once monthly until 100% compliance is achieved for 3 consecutive months. The audit results will be reviewed by the QAPI committee.	10-15-2025
K0211 SS = D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observation of the physical environment and interviews with the facility staff, it was determined that the facility staff failed to provide a safe and hazard free environment by failing to ensure exit discharges, exit locations and accesses are in accordance with NFPA 101:7.2 & 19.2 and means of egress is continuously maintained free of obstructions to full use in case of emergency. Failure to maintain exit	K0211		

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 reverse for further 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 LNHA	(X6) DATE 9-8-2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215161	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

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K0211 SS = D		K0211		10-15-2025

K0211
SS = D

Continued from page 1
discharges and unobstructed means of egress has the potential to cause harm to 50% of the occupants in the facility.

During the recertification survey on August 26, 2025, at approximately 2:30 p.m. it was determined through observation and confirmed through interview with the Assistant Administrator and the Director of Safety & Security:

1. The exterior automatic sliding doors in the Dining Room feature a single-cylinder keyed lock (from the exterior) and a ¼ turn thumb-turn knob on the interior and are labeled "in an emergency push to open". If these doors became locked there are no features to ensure unrestricted access in the event of a fire or similar emergency as required by NFPA 101:7.2.1.5.1, 19.2.2.2.4.

Failure to maintain exit discharges and unobstructed means of egress has the potential to cause harm to 50% of the occupants in the facility.

K0223
SS = E

Doors with Self-Closing Devices

CFR(s): NFPA 101

Doors with Self-Closing Devices

Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:

* Required manual fire alarm system; and

* Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and

* Automatic sprinkler system, if installed; and

* Loss of power.

18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8

This STANDARD is NOT MET as evidenced by:

Based on observation of the physical environment and interviews with the facility staff, it was determined

Provider's Plan of Correction (K0211 / K0223)

K223

A. After the walk through on August 26, 2025, the following doors were properly self-closed and latched to be smoke resistive as required by NFPA 101:7.2 (2012 ed.) and were corrected; No residents were affected.
   a. The cross-corridor fire door at the entrance to C wing was corrected to ensure that self-close and latching mechanism on the door frame was tightened and working properly, as noted on the 2567 as a result of surveyor walk-through. Correction was completed immediately August 26, 2025.
   b. The exterior emergency exit door at the bottom of the stairwell across from the EMS rooms was also corrected by tightening the closer on August 27, 2025.
   c. Emergency exit door #6 also corrected to properly latch to be smoke resistive as required and was corrected on August 27, 2025.

B. An audit was conducted on August 26, 2025 to ensure the staff provided a safe and hazard-free environment to ensure doors in horizontal exits and/or exit passageways properly self-close and latch to be smoke resistive as required by NFPA 101:7.2 (2012 ed.). No residents were affected.

C. Root cause analysis determined that the physical environment of the facility failed to ensure doors in horizontal exits and or exit passageways properly self-close and latch to be smoke resistive as required. In addition, the facility failed to ensure these doors properly self-closed and latch as required. This practice has the potential to cause harm to 50% of the occupants in the facility. Education will be given to the Assistant Administrator, Maintenance Director & Director of Safety & Security by the Administrator on September 8, 2025.

D. The Maintenance Director and Director of Safety & Security will conduct daily audits to ensure doors are in horizontal exits and or exit passageways properly self-close and latch to be smoke resistive as required. The audits will be conducted daily until 100% compliance is achieved for 5 consecutive days. Random audits will continue weekly until 100% compliance is achieved for 4 consecutive weeks, then monthly until 100% compliance is achieved for 3 consecutive months. The audit results will be reviewed by the QAPI committee.

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K0223 SS = E	Continued from page 2 that the facility staff failed to provide a safe and hazard-free environment by failing to ensure doors in horizontal exits and or exit passageways properly self-close and latch to be smoke resistive as required. Failure to ensure these doors properly self-close and latch as required has the potential to cause harm to 50% of the occupants in the facility. During the recertification survey on August 26, 2025, between 12:40 p.m. and 2:45 p.m. it was determined through observation and confirmed through interview with the Assistant Administrator and the Director of Safety & Security: 1. The following doors failed to properly self-close and latch to be smoke resistive as required by NFPA 101:7.2 (2012 ed.) a. Cross-corridor fire door at the entrance to C wing failed to self-close and latch. The latching mechanism on the door frame was loose. This was immediately corrected as a result of surveyor intervention. 1 b. The exterior emergency exit door at the bottom of the stairwell across from the EMS rooms. c. Emergency exit door #6 failed to properly latch to be smoke resistive as required. Doors in horizontal exits and/or exit passageways that do not properly self-close to be smoke resistive as required have the potential to cause harm to 50% of the occupants of the facility.	K0223	K345 A. The smoke detector in room C311 was observed to be hanging from the base by wires and was immediately corrected as noted in the 2567 as a result of surveyor walk-through. No residents were affected. B. In addition, required semi-annual visual inspections of the smoke detectors were initiated in August 2025 when the new Safety & Security Director gained awareness of this requirement and completed an immediate audit. No residents were affected. C. The root cause analysis determined that the facility staff failed to provide a safe and hazard free environment by not maintaining inspections and tests for all components of the building fire alarm system as required by NFPA 72. Education will be given to the Assistant Administrator, Maintenance Director & Director of Safety & Security by the Administrator on September 8, 2025. D. The Maintenance Director and Director of Safety & Security will conduct daily audits to maintain and provide semi and annual visual inspections of the smoke detectors. The audits will be conducted daily until 100% compliance is achieved for 5 consecutive days. Random audits will continue weekly until 100% compliance is achieved for 4 consecutive weeks, then monthly until 100% compliance is achieved for 3 consecutive months. The audit results will be reviewed by the QAPI committee.	10-15-2025
K0345 SS = D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on review of the facility's records, observation of the physical environment, and interview with	K0345		

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K0345 SS = D	Continued from page 3 facility staff it was determined that the facility staff failed to provide a safe and hazard free environment by not maintaining inspections and tests for all components of the building fire alarm system as required by NFPA 72. This failure has the potential to cause harm to 15% of the residents of the facility. During the recertification survey on August 26, 2025, at approximately 12:50 p.m. it was determined through observation and confirmed through interview with the Assistant Administrator and the Director of Safety & Security: 1. The smoke detector in room C311 was observed to be hanging from the base by wires. This was immediately corrected as a result of surveyor intervention. Note: Required semi-annual visual inspections of the smoke detectors were initiated in August of this year when the new Safety & Security Director gained awareness of this requirement. Failure to properly inspect and maintain the fire alarm system has the potential to promote harm to 15% of the occupants of the facility in the event of a fire.	K0345	K353 A. The three of six sprinkler heads in the washer room, one of two sprinkler heads in the dryer room and one sprinkler head in the access room in the rear of the dryers were observed covered with lint. These were cleaned immediately before the completion of the survey. No residents were affected. B. An audit was conducted immediately by the Maintenance Director and Director of Safety & Security to ensure the facility provides a safe and hazard-free environment to maintain all water-based fire suppression systems as required by NFPA 25. In addition to maintaining all water-based fire suppression systems. No residents were affected. C. The root cause analysis determined that the facility failed to properly inspect and maintain the fire suppression system that has the potential to promote harm to 50% of the occupants of the facility in the event of a fire. Education will be given to the Assistant Administrator, Maintenance Director & Director of Safety & Security by the Administrator on September 8, 2025. D. The Maintenance Director and Director of Safety & Security will conduct daily audits to maintain the fire suppression system and maintain all water-based fire suppression systems. The audits will be conducted daily until 100% compliance is achieved for 5 consecutive days. Random audits will continue weekly until 100% compliance is achieved for 4 consecutive weeks, then monthly until 100% compliance is achieved for 3 consecutive months. The audit results will be reviewed by the QAPI committee.	
K0353 SS = E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked __________________ b) Who provided system test ________________________ c) Water system supply source ______________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	K0353		

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K0353 SS = E	Continued from page 4 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation of the physical environment, review of the facility's records, and interview with facility staff it was determined that the facility staff failed to provide a safe and hazard free environment by not maintaining all water-based fire suppression systems as required by NFPA 25. This failure to maintain all water-based fire suppression systems as required has the potential to cause harm to 50% of the staff and residents. During the recertification survey on August 26, 2025, at approximately 2:20 p.m. it was determined through observation and confirmed through interview with the Assistant Administrator and the Director of Safety & Security: 1. Three of six sprinkler heads in the washer room, one of two sprinkler heads in the dryer room and one sprinkler head in the access room in the rear of the dryers were observed covered with lint. These were cleaned before the completion of the survey. Failure to properly inspect and maintain the fire suppression system has the potential to promote harm to 50% of the occupants of the facility in the event of a fire.	K0353	K372 A. The following penetrations/gaps/openings were corrected immediately after the physical environment survey walk-through. In addition, a ceiling tile was placed and/or replaced in the clothing store and in the room between the service corridor and the washer room in the laundry. The correction was made as noted in the 2567 before completion of the survey. No residents were affected. B. The Maintenance Director and/or Assistant Maintenance Director & Director of Safety & Security conducted a facility wide audit on 8/26/25 to ensure the facility provides a safe and hazard-free environment by providing separation of areas from corridors and other spaces throughout the facility as required, in including partitions as required in the event of a fire. No residents were affected. C. The root cause was determined that the facility staff failed to provide a safe and hazard free environment by not providing separation of areas from corridors and other spaces throughout the facility as required in addition to failing to provide partitions as required has the potential to cause harm to 50% of the staff and residents in event of a fire. No residents or staff were affected. Education will be given to the Assistant Administrator, Maintenance/Assistant Maintenance Director & Director of Safety & Security by the Administrator on September 8, 2025. D. The Maintenance and/or Assistance Director and Director of Safety & Security will conduct daily audits to maintain and provide a safe and hazard-free environment by providing separation of areas from corridors and other spaces in addition to providing partitions to prevent fire events. The audits will be conducted daily until 100% compliance is achieved for 5 consecutive days. Random audits will continue weekly until 100% compliance is achieved for 4 consecutive weeks, then monthly until 100% compliance is achieved for 3 consecutive months. The audit results will be reviewed by the QAPI committee.	
K0372 SS = E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by:	K0372		

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K0372 SS = E	Continued from page 5 Based on observation of the physical environment and interview with facility staff it was determined that the facility staff failed to provide a safe and hazard free environment by not providing separation of areas from corridors and other spaces throughout the facility as required. This failure to provide partitions as required has the potential to cause harm to 50% of the staff and residents. During the recertification survey on August 26, 2025, between 1:55 p.m. and 2:05 p.m. it was determined through observation and confirmed through interview with the Assistant Administrator and the Director of Safety & Security: 1. The following penetrations/gaps/openings were observed. These penetrations compromise the integrity of the smoke compartment in the event of fire or similar emergency. a. A ceiling tile was observed missing / out of place in the Clothing Store. This was corrected before completion of the survey. b. A ceiling tile was observed missing / out of place in the room between the service corridor and the washer room in the laundry. This was corrected before completion of the survey Failure to properly maintain smoke compartments has the potential to promote harm to 50% of the occupants of the facility in the event of a fire.	K0372	K918 A. The 4-hr load generator test report exercise is scheduled on September 16,17, 18 2025 for all three generators as documented in the TELS system under the new management company contract. The 2-hour load-bank generator tests were performed during the November 2024 scheduled test under load conditions in accordance with NFPA 99 and NFPA 110. The documentation will be readily available to review by October 15, 2025. No residents were affected. B. An audit was conducted by the Maintenance Director and Director of Safety & Security on 8/26/25 to ensure all Essential Electrical Systems (EES) installation, inspection and testing requirements of NFPA 99 and NFPA 110 to ensure a safe and hazard free environment by not properly inspecting and maintaining the essential electrical system (EES) which has the potential to promote documentations report of a 4-hr load generator test would be conducted and scheduled in TELS on September 16, 17, 18 2025 for all three generators to be within the last 3 years available for review in terms of the service contract. No residents or staff were affected. C. The root cause was determined that the facility failed to provide the scheduled documentation report of the 4 -hr. load generator test to harm to 100% of the occupants of the facility, no residents or staff were affected. D. The Maintenance Director and Director of Safety & Security will conduct weekly audits of the generator sets that are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours to maintain all essential electrical system (EES). The audits will be conducted daily until 100% compliance is achieved for 5 consecutive weeks. Random audits will continue monthly until 100% compliance is achieved for 3 consecutive months. The audit results will be reviewed by the QAPI committee.	10-15-2025
K0918 SS = F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals,	K0918		

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K0918 SS = F	Continued from page 6 and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on review of facility documents, observation of the physical environment, and interview with facility staff it was determined that the facility staff failed to provide a safe and hazard free environment by not fulfilling all Essential Electrical Systems (EES) installation, inspection and testing requirements of NFPA 99 and NFPA 110. The failure to install equipment, perform and/or document the tests and inspections of the emergency electrical system as required has the potential to cause harm to 100% of the staff and residents. During the recertification survey on August 26, 2025, at approximately 12:00 p.m. it was determined through observation and confirmed through interview with the Assistant Administrator and the Director of Safety & Security: 1. There was no documented report of a 4-hr. load test conducted within the last 3 years available for review at the time of the survey. Note: 2 hr. load-bank tests were performed in November 2024. Failure to properly inspect and maintain the essential electrical system has the potential to promote harm to 100% of the occupants of the facility.	K0918	K920 A. The Keurig, two refrigerators and microwave plugged into the 15 amp multi-outlet power strip device were removed immediately (8/26/25) from the MDS and infection control office and plugged directly into power outlets. No residents were affected or staff members, per NFPA safety features for medical equipment. B. A facility wide audit was conducted immediately by the Maintenance Director and Director of Safety and Security to ensure no power strips were being used in a patient care vicinity. No residents were affected. C. A root cause analysis determined that the facility failed to provide a safe and hazard free environment by failing to ensure safe working conditions free from electrical shock or related incidents. Therefore, the Keurig, refrigerators and microwave were removed from the multi-outlet device and plugged directly into the wall outlets in the MDS & infection control office. Per NFPA, healthcare-grade rating refers to safety features for medical equipment, not increased power capacity for appliances. In addition, the sum of the ampacity shall not exceed 75% of the ampacity of the flexible cord supplying the receptacles. NFPA 99:10.2.3.6. Education will be given to the Assistant Administrator, Maintenance Director & Director of Safety & Security by the Administrator on September 8, 2025. D. The Maintenance Director and Director of Safety & Security will conduct daily audits to ensure and monitor power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. The audits will be conducted daily until 100% compliance is achieved for 5 consecutive days. Random audits will continue weekly until 100% compliance is achieved for 4 consecutive weeks, then monthly until 100% compliance is achieved for 3 consecutive months. The audit results will be reviewed by the QAPI committee.	10-15-2025
K0920 SS = E Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords	K0920		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0920 SS = E Bldg. 01	Continued from page 7 Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation of the physical environment and interviews with the facility staff, it was determined that the facility staff failed to provide a safe and hazard free environment by failing to ensure safe working conditions free from electrical shock or related incidents. This failure promotes harm to 50% of the occupants of the facility. During the recertification survey on August 26, 2025, between 1:25 p.m. and 1:45 p.m. it was determined through observation and confirmed through interview with the Assistant Administrator and the Director of Safety & Security: 1. A Keurig and a refrigerator were plugged into a 15-amp healthcare grade multi-outlet device in the MDS office. 2. Two refrigerators and a microwave were plugged into a 15-amp multi-outlet device in the Infection Control office. Appliances may only be plugged directly into AC wall outlets per NFPA 101:9.1.2, NFPA 70. Note: Per NFPA, healthcare-grade rating refers to safety features for medical equipment, not increased power capacity for appliances. In addition, the sum of the ampacity shall not exceed 75% of the ampacity of the flexible cord supplying the receptacles. NFPA 99:10.2.3.6.	K0920		10-15-2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215161	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025
NAME OF PROVIDER OR SUPPLIER Charlotte Hall Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 29449 CHARLOTTE HALL ROAD , CHARLOTTE HALL, Maryland, 20622	

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K0920 SS = E Bldg. 01	Continued from page 8 Failure to ensure compliance with NFPA 70, 99 & 101 promotes harm to 50% of the occupants of the facility.	K0920		10-15-2025

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215161	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

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E0000	Initial Comments A Life Safety Code recertification survey conducted on August 26, 2025, between 10:45 a.m. and 4:15 p.m. at your facility for the purpose of determining compliance with Medicare & Medicaid requirements by a Fire and Life Safety Code surveyor from MDH-OHCQ. This facility occupies a three-story Type II constructed facility. The SNF portions are identified as the A, B & C wings as well as the "Core". It does not have an attic. There is interstitial space between some Areas of the 3rd floor and the roof which contains no storage or mechanical equipment and the Type II construction is maintained. It has a partial basement. It is fully automatic sprinkler protected. Survey activities include observation of the physical environment, review of facility records, review of facility emergency preparedness plan, observation of staff practices, and interviews with staff members. There were no deficiencies of the Emergency Preparedness Program requirements observed at the time of the survey.	E0000		

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 reverse for further 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ______	C 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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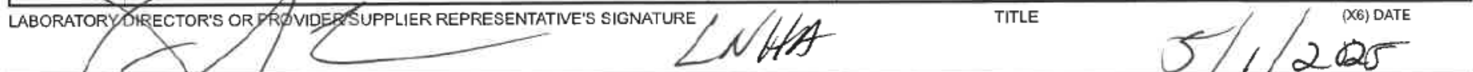
F 000	INITIAL COMMENTS A complaint survey was conducted by A and M Financial, LLC on behalf of the Maryland Department of Health, Office of Health Care Quality, from March 25, 2025 - April 4, 2025. The facility was found to not be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: March 25, 2025 - April 4, 2025 Survey Census: 204 Sample Size: 40	F 000	F580 The facility's agency nurse failed to notify the responsible party, G32, regarding a hospital transfer of resident, R17. The leadership was not aware of any notification issues; therefore, immediate action was not taken. Although all of Charlotte Hall Veterans Services' residents & ACOC, those requiring a hospital transfer due to change of condition, have the potential to be impacted by this deficient practice, no other residents have been identified as being affected. Implement measures and systemic changes:	5/16/2025
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580	On April 24, 2025, the Senior Nurse Consultant (SNC) in-serviced the Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Unit managers (UM) (Registered Nurses x3 and Licensed Practical Nurses x3), Clinical Competency Coordinator (CCC), and RN Supervisor on notifying the Responsible Party (RP) of acute change of condition with hospital transfer. In-service also included the use of SBAR to document notification of the RP for changes of condition, as well as ongoing notification attempts if unable to reach RP. Continued on next page...	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: LNHA | TITLE | (X6) DATE: 5/1/2025

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.

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F 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to immediately notify the Resident court appointed Guardian (G32) when Resident (R17) experienced a significant change and deterioration of a life-threatening condition for one of 40 sampled residents. The facility census was 204. The Findings Include: Review of R17's Face Sheet documented R17 was admitted on [redacted] The face sheet showed G32 was a medical court appointed	F 580	F580 Continued... Starting April 24, 2025, ADHS/ADHS/UM/CCC/RN Supervisor will utilize the written in-services provided by the SNC to educate at least the licensed nurses on RP notification, communication, and documentation. This will be completed by May 15, 2025. · Notification and SBAR in-services will be added to new hire orientation. Facility will monitor compliance by completing the "Notification Audit Tool". · DHS/ADHS will provide written disciplinary to nurses who failed to provide the appropriate and timely notification. Evaluation of performance: ·Starting May 1, 2025, the Registered Nurse will complete the notification audit tool daily to identify if the RP was notified of the resident's change of condition with hospital/ER transfer. · If notification was not completed, UM/ADHS/DHS/Nursing Supervisor will notify the appropriate RP as soon as the noncompliance is identified. Audit to be completed monthly x 3 months with findings evaluated in the monthly Quality Assurance and Performance Improvement meetings.	5/16/2025

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F 580	Continued From page 2 guardian. Review of R17's care plan dated 7/25/2023 directed staff to notify G32 of any changes to R17's health status. Record Review of the annual Minimum Data Set assessment (MDS), dated 1/16/2024, revealed R17 had a BIMS score of 00/15 (indicating severe mental impairment). R17 was dependent on staff regarding activities of daily living (ADLs). Record review of R17's SBAR form dated [redacted] at 06:04 AM, Licensed Practical Nurse (LPN)33 documented R17 had an elevated respiration. R17 was not able to respond to tactile stimuli. MD made aware and gave an order given to send, R17 to hospital for evaluation. Record review on R17's progress notes dated [redacted] 12:11 PM, staff documented R17 returned from Emergency Room (ER) visit with the same complaint of tachycardia and was given morphine sulfate and lorazepam at the ER. R17 remained stable and was on oxygen. Record Review of R17's Progress Note staff documented on [redacted] 08:59 PM, R17 was noted with no respiration nor pulse. R17 was pronounced deceased at 7:00 PM. During an interview on 3/28/2025 at 9:26 AM, LPN15 revealed when there was a change in condition staff were required to call and document in the progress notes that there was a change in condition and make attempts to notify the Resident Representative as soon as possible. When staff fail to reach the Resident Representative, they should make several	F 580		5/16/2025

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F 580	Continued From page 3 attempts until they reach them. LPN15 concluded she was unable to see where staff documented they contacted R17s guardian, G32. During an interview on 3/28/2025 at 10:30 AM, G32 revealed she was R17's state appointed medical guardian. G32 stated on 2/11/2024 she was disappointed when facility staff sent R17 to the hospital without notifying her. During an interview on 3/28/2025 at 12:15 PM, the Director of Nursing (DON) stated, R17 had a court appointed guardian and explained on 2/11/2024, R17 was sent to the ER. DON stated staff should have made sure G32 was notified when staff sent R17 to hospital. During an interview on 4/1/2025 at 9:10 AM, Social Worker Case Manager (SWCM)5 revealed she was not involved when R17 was sent to hospital. SWCM5 stated she would have expected staff to contact R17's guardian when R17 was sent to hospital. During an interview on 4/1/2025 at 10:46 AM, the Assistant Nursing Home Administrator (ANHA)25, she stated she remembered when G32 raised concerns, regarding failure to be contacted when staff sent R17 to hospital without notifying her. ANHA25 stated the staff on shift at that time was an agency nurse who did not follow facility policy. During an interview on 4/3/2025 at 12:38 PM, the Administrator said nurses or the social worker should contact the family when there was a change in condition.	F 580		5/16/2025
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		

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F 584	Continued From page 4 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584	F584 1) The two wings (A&B) were corrected on 5/2/24 and the Code Purple was cleared, along with the power restored to ensure the residents environmental was safe and comfortable with a temperature range of 71 to 81 degrees. 2) All residents have the potential to be impacted. The DON in-serviced nursing staff on 4/30/24 through 5/2/24 for signs and symptoms of heat related illness and initiated staff to monitor resident temperatures every shift through 5/3/24 to also ensure the temperature was maintained on other wings for the safety of all residents, and no residents were adversely affected. The facility Maintenance Director and maintenance/safety staff began weekly audits on May 2, 2025, to maintain safe, comfortable temps on the units (including A and B) along with individual preferences to be part of the resident plan of care, as necessary. To also ensure the IDT team conducts audits during planned maintenance of the cooling systems and monitored monthly by the Quality Assurance Nurse. ...continued	5/16/2025

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F 584	Continued From page 5 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review and interviews during a complaint survey, the facility failed to ensure the resident environment was safe and comfortable for two of four occupied care wings. Specifically, the facility failed to maintain safe, comfortable temperatures on the A and B wings of the facility during planned maintenance of the cooling system; temperatures on these wings were consistently above 81 degrees Fahrenheit for approximately 48 hours. Cross reference to F684: Quality of care The findings include: The Procedure titled "Code Purple: Severe Hot Weather with Loss of Cooling", last revised 2/1/15, documented the procedure should be followed to prevent abnormally high body temperature if there was a loss of cooling function during hot weather when the facility's temperatures reach 81 degrees Fahrenheit and remained so for 4 hours. Action steps to be taken in the event of a Code Purple included the following: to keep informed of weather bulletins, have a portable NOAA weather radio available, move patients/residents to another air-conditioned part of the facility if available, conduct in-service training to monitor signs and symptoms of heat-related illnesses and proper response, notify the county Emergency Management Agency (EMA) and maintain contact to keep them informed of potential needs if the situation deteriorated, encourage patients/residents to take in more fluids and keep	F 584	F584 continued 3) The DON & Maintenance Director began additional education on 4/30/2025 in the event of a Code Purple, utilizing the last revised 6/18/2024 procedure to prevent high body temperature of our residents during the preventive and/or maintenance servicing of the cooling systems. In addition, the NHA and/or AIT will keep staff informed of weather bulletins and action steps to be taken immediately and by 5/16/2025. The Code Purple Action Steps should be followed: Keep informed of all area weather bulletins and monitor for updates. Have a portable NOAA Weather Radio available and make sure extra batteries are available. The most qualified staff member on duty will assume the Incident Commander Position. The Incident Commander and/or designee should alert all partners to the Code "Purple" status. If not already on the premises, notify the (Refer to the Contact List in the Administrative Section: Administrator, Maintenance Director, Director of Health Services, County EMA Director, Area Vice President, Environmental Consultant, Emergency Compliance Specialist and Medical Director. If necessary, activate the Staff Recall Roster. Contact the service provider to notify of issue. continued...	5/16/2025

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F 584	Continued From page 6 hydrated and to force fluids if necessary, record fluid intake, provide cold wash clothes as needed, continuously evaluate patients/residents to ensure their safety and welfare are not being jeopardized and monitor body and environmental temperatures. Review of facility's Code Purple timeline and documentation revealed the following: On 4/29/24 the cooling tower which serviced the A and B wings was taken out of service for scheduled maintenance. Since this was a planned outage, portable cooling units had been rented and placed on the impacted wings. On 4/30/2024, outside temperatures rose and the portable units on the units were unable to keep up with the demand to keep the building cool. After temperatures in the building were above 81 degrees for more than four hours in the building a Code Purple was enacted at 4:00 PM. Maintenance and security staff were assigned to check/monitor temperatures for the impacted areas. Upon request, the facility could not provide temperature monitoring logs from 4/30/24 and prior to 4:30 PM on 5/1/24. Review of temperatures logs from 4:30 PM on 5/1/24 until 10:30 AM on 5/2/24, revealed hourly temperatures were recorded to be consistently above 81 degrees on the 2nd and 3rd floor care units on the A and B wings. On 5/1/24 at 9:18 AM, the facility notified the County EMA of the Code Purple.	F 584	F584 Continued Move patients/residents to another air-conditioned part of the facility, if available. Encourage patients/residents to take in more fluids and keep hydrated. Encourage fluids if necessary and record fluid intake. Provide cold wash cloths as needed. Establish and maintain contact with the County Emergency Management Agency (EMA) to advise them of the situation and keep them informed of potential needs if the situation deteriorates. Conduct an in-service training for staff on the signs and symptoms of heat related illness and proper responses. Be prepared for an extended shelter-in-place period. Open windows to let cooler outside air in and utilize fans to move air. Monitor body temperatures. Continuously evaluate patients/residents to ensure their safety and welfare are not being jeopardized. CALL 911 if a patient/resident or staff member appears to be in danger of heat-related stress. If a loss of power occurs, contact the power company to determine the projected duration. Stay in contact with the EMA Director for recommendations concerning evacuation or shelter-in-place. If conditions warrant, or the situation is expected to deteriorate to the point where patient/resident safety and welfare are threatened then the decision to evacuate must be made. Continued...	5/16/2025

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F 584	Continued From page 7 On 5/1/24 facility staff went out to purchase fans to provide to the residents. On 5/1/24 at 10:47 AM, the facility was contacted by the County EMA, who offered assistance and additional resources. On 5/1/24 at 11:47 AM, a representative from the State Department of Emergency Management reached out to the facility to inquire about what was occurring at the facility and what was being done. On 5/1/24 at 2:00 PM, a meeting was held with the state Department of Emergency Management to discuss unmet needs and the potential for future requests. On 5/1/24 at 2:00 PM, County EMA provided 9 large fans to assist with air movement which were delivered to the facility. On 5/1/24 at 6:30 PM temperatures were documented to have reached over 90 degrees on the third-floor care units of A and B Wing and the second-floor unit of B Wing. On 5/1/24 at 9:22 PM, it was decided that residents from unit 3A should be moved to the vacant unit on 1A after morning medication pass on 5/2/24 in order to give staff time to prepare the vacant unit. On 5/2/24 at 9:11 AM, unit 1A was prepared for residents to move to, however, the move was placed on hold after it was determined that the cooling towers would be functional again by 11:30 AM.	F 584	F584 Continued 4) The Quality Assurance Nurse and Maintenance Director will randomly record and monitor 3 rooms on each unit weekly beginning 5/2/25. Random audits will be conducted once weekly or until 100% compliance is achieved for three consecutive weeks. Audits will be reviewed monthly by the Quality Assurance Committee.	5/16/2025

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F 584	Continued From page 8 On 5/2/24 at 11:30 AM, the power was restored to the cooling towers. On 5/2/24 at 12:01 PM, the Code Purple was cleared by the Nursing Home Administrator (NHA). A Rehearsal/Drills/Exercise After Action Report Form completed for the Code Purple on 4/30/24 read "describe the plan of action to address any problems notes during the exercise/drill." The listed actions included that the facility ensure different consistencies of fluids were available based on resident need, that all fluid intake is documented in the resident chart and that vacant units in the facility should be move in ready. An "improvement plan" section included on the form listed the following: lesson learned, recommendation and primary person responsible with a start and completion date was not completed. During an interview on 3/29/24 at 11:30 AM, the County EMA representative recalled the facility had taken the cooling system offline for maintenance and the temperatures outside were unseasonably hot. They stated EMA was informed the day after the Code Purple had been enacted. They stated they offered resources and assistance to the facility as well as referred them to the State Emergency Management Department. They stated that since it was a planned event to take the cooling systems offline, the expectation would have been for EMA to be notified in advance to plan for needed resources and that emergency management agencies be notified at the time a Code Purple was enacted. They stated that the importance of timeliness in making notification was conveyed to facility	F 584		5/16/2025

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management.

During an interview on 3/31/25 at 1:16 PM, Registered Nurse Unit Manager (RNUM) #10 stated during the Code Purple, staff were educated to monitor residents for signs of heat exhaustion and dehydration and to provide additional hydration. They stated it was an "all hands-on deck" situation", and there were no specific resident assignments to monitor for hydration. They stated they were concerned about residents' comfort levels and the potential for dehydration and heat exhaustion at the time. They stated it was also difficult for the staff to work in the heat.

During an interview on 3/31/25 at 1:59 PM, the Director of Nursing (DON) stated that nursing staff were educated during the Code Purple to monitor residents for signs of heat exhaustion or changes in condition and provide additional fluids. They stated that no additional education was conducted with nursing staff in response to the Code Purple after it was cleared.

During an interview on 4/1/25 at 11:20 AM, the Director of Maintenance (DOM) stated that the facility had planned to have between 6-8 portable cooling units while the cooling tower was having scheduled maintenance. They stated portable cooling units were placed in common areas in the impacted wings. They stated they started taking temperatures in the hallways of impacted units on 4/30/24; temperatures were not taken in resident rooms but stated that resident rooms would have been hotter than the hallways. They stated it was "extremely hot" the building and they set up fans to try to get more air flow and fans were placed in resident rooms. They stated it was unpredictable

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F 584	Continued From page 10 for the weather to be as hot as it was during that time of year. During an interview on 4/2/25 at 1:25 PM, the Safety and Security Director (SSD) stated the facility enacted a Code Purple on 4/30/24 at 4:00 PM. They stated maintenance staff had started to monitor temperatures on 4/30/24 but were not keeping a log of the temperatures and were "winging it". They stated they created a form on 5/1/24 to track the temperatures for impacted areas and instructed maintenance and security staff to record temperatures every hour which started at 4:30 PM on 5/1/24. They stated temperatures were monitored and recorded in the hallways on the impacted units, however, that resident rooms would have been even hotter. They stated on 5/1/24 they went out to purchase fans. They stated portable cooling units were placed in the hallways but that the electrical breakers could trip if too many cooling units were running at the same time. They stated on the morning of 5/2/24 they were informed to start preparing rooms on a vacant unit. The SSD stated they participated in a meeting following the Code Purple and they documented problems identified during the code. They stated the facility had ample water and Gatorade to disperse to residents during the code, however, it was identified the need for additional need for thickened liquids/residents who required a different consistency was not taken into account and needed to be more readily available on the units. They stated it was also identified that in planning for the cooling system outage, the vacant units should be prepared to be move-in ready in advance. During an interview on 4/3/25 at 12:01 PM, the	F 584		5/16/2025

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F 584	Continued From page 11 NHA stated that the cooling system maintenance was planned, and that maintenance had already been completed for cooling tower for the other wings. They confirmed that the temperatures in the building were found to be above 81 degrees starting at approximately 12:00 PM on 4/30/24 and after 4 hours a Code Purple was enacted; the Code Purple was cleared at 12:00 PM on 5/2/24 and lasted approximately 48 hours. They stated they did not recall whether anyone had reviewed or discussed the weather forecast prior to the cooling towers being taken out of service. They stated notifications and actions to manage the heat and monitor residents were happening simultaneously. They stated it was decided on the night of 5/1/24 that residents should be moved the following morning because the temperatures in the building were still consistently hot. They stated vacant units were prepared to move residents; however, it was decided not to move residents since they were informed on the morning of 5/2/24 that the cooling towers would soon be functional. They stated during review of the Code Purple, it was identified that vacant units should be move-in ready in event relocation is needed, that resident fluid intake should be documented and that there was an increased need for thickened liquids. They stated with all staff dispersing fluids to promote hydration, it was difficult to determine how much fluid was provided to individual residents.	F 584		5/16/2025
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		

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F 684	Continued From page 12 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews during a complaint survey, the facility failed to ensure each resident was provided care and treatment in accordance with professional standards of practice for one resident (Resident #9) of 40 sampled residents. Specifically, the facility failed to ensure Resident #9, a resident at risk for dehydration, was monitored for heat related illness and provided with sufficient hydration when temperatures in the building rose above 81 degrees from 4/30/24 until 5/2/24. On the morning of [redacted] Resident #9 was found nonresponsive with an elevated temperature and was sent to the hospital where they were treated for heat exhaustion and dehydration. Resident #9 experienced a significant change in condition following this event. This failure resulted in actual harm for Resident #9 that did not rise to the level of immediate jeopardy. Cross reference to F584: safe, clean, comfortable, homelike environment The findings include: According to the Centers for Disease Control and Prevention (CDC) guidance, last updated 6/25/24, retrieved from https://www.cdc.gov/heat-health/risk-factors/heat-and-older-adults-aged-65.html, older adults are at increased risk for heat related illness because they do not adjust as well to sudden changes in	F 684	F684 1. Cannot retroactively correct. R9 no longer resides at the facility. 2) All residents have the potential to be impacted by loss of cooling events during hot weather. The facility wide audits were conducted for all residents who have a current order for thickened liquids on 5/5/2025. DON in-serviced nursing staff on 4/30/24 through 5/2/24 for monitoring of signs and symptoms of heat related illness and initiated staff to monitor resident temperatures on every shift through 5/3/24 to also ensure the temperature was maintained below 81 degrees on other wings for the safety of all residents. The Quality Assurance Nurse monitors the par levels of thickened liquids on a routine basis to keep it above a 3-day supply, to ensure thickened liquid is readily available and on hand for all residents who have an order for thickened liquids which may include compromised residents. In addition, the thickened liquid is stocked in the kitchen with the Emergency Supplies and has a date of expiration of 4/2026. Continued...	5/16/2025

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F 684	Continued From page 13 temperature, are more likely to have a chronic medical condition that can change normal body responses to heat and are more likely to take prescription medicines that affect the body's ability to control its temperature or sweat. Guidance included that older adults should stay in air-conditioned buildings as much as possible and should not rely on a fan as the main cooling source when it's really hot outside; should drink more water than usual, wear loose/ lightweight clothing and take cool showers or baths to cool down. Use of fans was indicated only if indoor temperatures were less than 90 degrees. In temperatures above 90 degrees, a fan could increase body temperature. The Procedure titled "Code Purple: Severe Hot Weather with Loss of Cooling", last revised 2/1/15, documented action steps to be taken in the event of a Code Purple which included the following: move patients/residents to another air-conditioned part of the facility if available, encourage patients/residents to take in more fluids and keep hydrated, to force fluids if necessary, record fluid intake, provide cold wash clothes as needed, continuously evaluate patients/residents to ensure their safety and welfare are not being jeopardized and monitor body and environmental temperatures. Review of facility's Code Purple timeline and documentation revealed on 4/29/24 the cooling tower which serviced the A and B wings was taken out of service for scheduled maintenance and which impacted Resident #9's unit (3A). On 4/30/2024, outside temperatures rose and portable cooling units were unable to keep up with the demand to keep the building cool. After temperatures above 81 degrees were recorded	F 684	F684 continued The root caused analysis was determined that the facility missed the opportunity to ensure each resident was provided care and treatment in accordance with professional standards of practice and were unable to keep up with the demand to cool the facility with insufficient oversight for observing the signs and symptoms to assess for acute distress of compromised residents at risk for dehydration. Staff also lacked the ability to monitor body heat related illness and elevated environment temperatures and provided insufficient hydration when temperatures rose above 81 degrees from 4/30/24 until 5/2/2024. Changes were made to the Code Purple protocol after the incident and corporate revised the procedure on 6/18/24 to ensure the at-risk residents or compromised residents were safe, comfortable during an emergency hot weather or planned/unplanned events related to loss of cooling. The Unit Managers and nursing supervisors were educated on documenting fluid intake on the ADL Flow Sheet and progress notes in the EMR system of compromised residents during an emergency incident. Continued...	5/16/2025

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for more than four hours, a Code Purple was enacted at 4:00 PM on 4/30/24. Upon request, the facility could not provide temperature monitoring/logs from 4/30/24 and prior to 4:30 PM on 5/1/24. From 4:30 PM on 5/1/24 until 10:30 AM on 5/2/24, hourly temperatures were recorded during 18 opportunities on unit 3A; of the 18 recorded temperatures, 16 of the temperatures recorded to be above 81 degrees. On 5/1/24 temperatures in the evening hours on Unit 3A reached over 90 degrees.

Review of staff education provided on 4/30/24 and 5/1/24 revealed staff were educated to look for the following signs of heat related illness: high body temperature, red/hot/damp skin, fast pulse, headache/dizziness, nausea or vomiting and confusion/loss of consciousness. Actions for staff to take included: place cool, wet clothes on the skin, encourage light clothing, move to a cool area as able, offer plenty of fluids to drink and notify the provider of any change in a resident's condition.

Resident #9 was admitted to the facility with diagnosis which included Parkinson's Disease, dementia, and dysphagia (swallowing disorder). The Minimum Data Set (an assessment tool) dated [redacted] documented the resident was assessed with a Brief Interview for Mental Status (BIMS) score of 3/15 which was indicative of impaired cognition. Resident #9 was assessed as being dependent on staff to complete most activities of daily living.

The Nutrition Care Plan, initiated 7/27/23, documented the resident was at risk for dehydration. Interventions included staff were to observe for signs and symptoms of dehydration.

F 684

F684 — 5/16/2025

Education for monitoring body and environmental temperatures will be completed by 5/16/25 to all staff by the Quality Assurance Nurse and DON. Education will be conducted to the nursing staff by the Quality Assurance Nurse and DON to include assessment of residents on thickened liquids and notification to resident's family members/representatives related to acute change of condition to be recorded immediately in the EMR by 5/16/2025.

3) A facility wide education began on 4/30/25 by the DON, Maintenance Director and Quality Assurance Nurse to ensure all facility residents are not at risk for dehydration, heat related illness and/or Significant Change in Condition (CIC) following a Code Purple procedure in accordance with professional standards of practice.

Education will continue to be completed by 5/16/2025, according to CDC guidance last updated on 6/25/24, along with the last revised Code Purple procedure dated 6/18/24 for at risk heat related illness.

continued...

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F 684	Continued From page 15 The goal of the care plan was for Resident #9 to remain adequately hydrated as evidenced by good skin turgor, pink and moist mucous membranes and sufficient fluid intake. A Dietary Order dated 1/10/24 ordered the resident to receive honey thick liquids. A Physician Order dated 3/12/24 ordered staff to encourage thickened water intake during every shift. A Provider Note dated 4/24/24 documented Resident #9 seen by their provider and was assessed to be stable, afebrile and not in any acute distress. The resident was seen for a cough and prescribed Geri-tussin every 12 hours for 5 days. Review of Resident #9's electronic medical record (EMR) documented the resident received 240 millimeters of fluid with breakfast on 4/30/24; no additional fluids were documented. On 5/1/24, the resident was documented to have received 450 milliliters (15.2 ounces) of fluid across all shifts. No fluids were documented to have been provided on 5/2/24. Review of Resident #9's EMR revealed no progress notes were documented for the resident from the time they were seen by their provider on 4/24/24 until the morning of [redacted] A Nursing Progress Note dated [redacted] documented Resident #9 was found nonresponsive during care rounding. Vitals signs were obtained, and the resident's temperature was found to be 102 degrees. Orders were given to send the resident to the hospital for further	F 684	F684 4. The Quality Assurance Nurse will monitor the temperature log sheets and Code Purple Action Steps in the event of hot weather with loss of cooling, monthly x3 or until substantial compliance of 100% is achieved. Education added to new hire orientation to ensure staff are aware of the Code Purple Policy, along with compromised residents and those that are ordered thickened liquids. Results of audit will be presented to the QA committee monthly for further evaluation, recommendations and sustainability.	5/16/2025

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F 684	Continued From page 16 evaluation and the resident was transported to the emergency room at 10:30 AM via emergency medical services (EMS). A Hospital Discharge Summary dated [redacted] documented Resident #9 was confused at baseline but was usually verbal. EMS staff reported there was no air conditioning at the facility where the resident resided. Resident #9 was given 1.5 liters of fluid from EMS and the emergency room collectively. The resident was admitted to the hospital for further evaluation and management of hyponatremia related to decreased oral intake with dehydration due to heat exhaustion. Resident #9 was treated for dehydration and hyponatremia which was resolved with IV hydration. During an interview on 3/31/25 at 1:16 PM, Registered Nurse Unit Manager (RNUM) #10 stated during the Code Purple, staff were educated to monitor residents for signs of heat exhaustion and dehydration and to round to provide additional hydration. They stated it was an "all hands-on deck situation" and there were no specific resident assignments to monitor for hydration. They stated fluids provided should be documented in the EMR. RNUM #10 reviewed Resident #9's EMR and stated there were no nursing progress notes throughout the Code Purple. They stated Resident #9 required encouragement and assistance to accept fluids. They stated Resident #9 had mumbled speech and could express some needs, however, would not have been someone who could voice complaint about the heat. They stated Resident #9 was found nonresponsive and with a fever on the morning of [redacted] and was sent out to the hospital. They reviewed Resident #9's hospital	F 684		5/16/2025

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discharge summary and stated the labs obtained were significant for dehydration.

During an interview on 3/31/25 at 1:59 PM, the Director of Nursing (DON) stated that nursing staff were educated during the Code Purple to monitor residents for signs of heat exhaustion or changes in condition and to provide additional fluids. They stated routine charting of hydration was not completed during the code. They stated additional education had not been completed with nursing staff in response to the Code Purple after it was cleared. They stated they had reviewed Resident #9's EMR's and noted there was a lack of documentation. They stated Resident #9 was at risk for dehydration due to their diagnoses.

During an interview on 4/1/25 at 9:08 AM, Social Work Case Manager (SWCM) #5 stated they were Resident #9's assigned case manager. They stated Resident #9 had mumbled speech but could express their needs in a limited capacity. They stated they had started calling residents' family members/representatives on the morning of [redacted] to inform them of moving residents to another area of the building, however, residents were not moved, and Resident #9 was sent out to the hospital that morning. They stated Resident #9's family expressed concern to them about the resident being impacted by the heat but that by the time the resident returned from the hospital, the cooling system was functional again.

During an interview on 4/1/25 at 2:04 PM, the Medical Director stated Resident #9 had a diagnosis of advanced Parkinson's Disease and was prescribed thickened liquids to prevent aspiration. They stated staff at the facility

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monitored the resident's hydration and encouraged fluids. They stated residents who were prescribed thickened liquids were at increased risk for dehydration because they did not receive as much hydration from thickened fluid intake. They stated they had reviewed Resident #9's EMR and noted that there was no nursing progress notes during the time the facility experienced increased temperatures on the unit. They stated it was important to encourage fluids and stay proactive in observing residents for any change that could indicate heat related symptoms. They stated when Resident #9 was sent to the hospital, the labs were indicative of dehydration and hyponatremia. The Medical Director stated Resident #9 had worsening encephalopathy and comorbidities which contributed to the change in their condition.

During an interview on 4/2/25 at 1:06 PM, Nurse Practitioner #24 stated they had been the primary care provider for Resident #9. They stated they had seen Resident #9 multiple times prior to the resident's hospitalization and the resident had been stable. They stated Resident #9 was at risk for dehydration and staff were to encourage fluids. They stated they went to assess Resident #9 on the morning of [redacted] after the nurse reported the resident had a fever and was nonresponsive. They stated the cooling units in the building had not been working for two days and the resident's room was very hot when they arrived. They stated they immediately called out for a cold compress and gave the order that the resident should be sent to the emergency room. They stated they did not don't recall any additional interventions implemented during the cooling system outage.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	Continued From page 19 During an interview on 4/2/25 at 1:25 PM, the Safety and Security Director (SSD) stated they participated in a meeting following the Code Purple. They stated the facility had ample water and Gatorade to disperse to residents during the code, however, it was identified the need for additional need for thickened liquids/residents who required a different consistency was not taken into account. They stated it was identified that thickened liquids needed to be more available on the care units and not kept in storage in the kitchen. It was also identified that fluid intake should be documented in resident medical charts.	F 684		5/16/2025

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S 000	Initial Comments A complaint survey was conducted by A and M Financial, LLC on behalf of the Maryland Department of Health, Office of Health Care Quality, from March 25, 2025 - April 4, 2025. The facility was found to not be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: March 25, 2025 - April 4, 2025 Survey Census: 204 Sample Size: 40	S 000	Cross reference F580 S580 The facility's agency nurse failed to notify the responsible party, G32, regarding a hospital transfer of resident, R17. The leadership was not aware of any notification issues; therefore, immediate action was not taken. Although all of Charlotte Hall Veterans Services' residents & ACOC, those requiring a hospital transfer due to change of condition, have the potential to be impacted by this deficient practice, no other residents have been identified as being affected. Implement measures and systemic changes: On April 24, 2025, the Senior Nurse Consultant (SNC) in-serviced the Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Unit managers (UM) (Registered Nurses x3 and Licensed Practical Nurses x3), Clinical Competency Coordinator (CCC), and RN Supervisor on notifying the Responsible Party (RP) of acute change of condition with hospital transfer. In-service also included the use of SBAR to document notification of the RP for changes of condition, as well as ongoing notification attempts if unable to reach RP. Continued on next page...	5/16/2025
S 580	10.07.02.18 C Nursing Services - Care 24 Hours a Day .18 Nursing Services. C. Nursing Care 24 Hours a Day. The administrator shall employ sufficient and satisfactory licensed nursing service personnel and support personnel to: (1) Be on duty 24 hours a day; (2) Provide appropriate bedside care; and (3) Ensure that a resident: (a) Receives treatments, medications, and diet as prescribed; (b) Receives rehabilitative nursing care as needed; (c) Receives proper care to prevent pressure ulcers and deformities; (d) Is kept comfortable, clean, and well-groomed;	S 580		

OHCQ
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: LNHA

(X6) DATE: 5/1/2025

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. BUILDING: ______ B. WING ______	C 04/04/2025

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S 580	Continued From page 1 (e) Is protected from accident, injury, and infection; (f) Is encouraged, assisted, and trained in self-care and group activities; and (g) Receives prompt and appropriate responses to requests for assistance. This Regulation is not met as evidenced by: Based on record review and interviews during a complaint survey, the facility failed to ensure each resident was provided care and treatment in accordance with professional standards of practice for one resident (Resident #9) of 40 sampled residents. Specifically, the facility failed to ensure Resident #9, a resident at risk for dehydration, was monitored for heat related illness and provided with sufficient hydration when temperatures in the building rose above 81 degrees from 4/30/24 until 5/2/24. On the morning of [redacted], Resident #9 was found nonresponsive with an elevated temperature and was sent to the hospital where they were treated for heat exhaustion and dehydration. Resident #9 experienced a significant change in condition following this event. This failure resulted in actual harm for Resident #9 that did not rise to the level of immediate jeopardy. Cross reference to F584: safe, clean, comfortable, homelike environment The findings include: According to the Centers for Disease Control and Prevention (CDC) guidance, last updated 6/25/24, retrieved from https://www.cdc.gov/heat-health/risk-factors/heat-and-older-adults-aged-65.html, older adults are at	S 580	F580 Continued... Starting April 24, 2025, ADHS/ADHS/UM/CCC/RN Supervisor will utilize the written in-services provided by the SNC to educate the licensed nurses on RP notification, communication, and documentation. This will be completed by May 15, 2025. · Notification and SBAR in-services will be added to new hire orientation. Facility will monitor compliance by completing the "Notification Audit Tool". · DHS/ADHS will provide written disciplinary to nurses who failed to provide the appropriate and timely notification. Evaluation of performance: · Starting May 1, 2025, the Registered Nurse will complete the notification audit tool daily to identify if the RP was notified of the resident's change of condition with hospital/ER transfer. · If notification was not completed, UM/ADHS/DHS/Nursing Supervisor will notify the appropriate RP as soon as the noncompliance is identified. · Audit to be completed monthly x 3 months with findings evaluated in the monthly Quality Assurance and Performance Improvement meetings.	5/16/2025

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S 580	Continued From page 2 increased risk for heat related illness because they do not adjust as well to sudden changes in temperature, are more likely to have a chronic medical condition that can change normal body responses to heat and are more likely to take prescription medicines that affect the body's ability to control its temperature or sweat. Guidance included that older adults should stay in air-conditioned buildings as much as possible and should not rely on a fan as the main cooling source when it's really hot outside; should drink more water than usual, wear loose/ lightweight clothing and take cool showers or baths to cool down. Use of fans was indicated only if indoor temperatures were less than 90 degrees. In temperatures above 90 degrees, a fan could increase body temperature. The Procedure titled "Code Purple: Severe Hot Weather with Loss of Cooling", last revised 2/1/15, documented action steps to be taken in the event of a Code Purple which included the following: move patients/residents to another air-conditioned part of the facility if available, encourage patients/residents to take in more fluids and keep hydrated, to force fluids if necessary, record fluid intake, provide cold wash clothes as needed, continuously evaluate patients/residents to ensure their safety and welfare are not being jeopardized and monitor body and environmental temperatures. Review of facility's Code Purple timeline and documentation revealed on 4/29/24 the cooling tower which serviced the A and B wings was taken out of service for scheduled maintenance and which impacted Resident #9's unit (3A). On 4/30/2024, outside temperatures rose and portable cooling units were unable to keep up with the demand to keep the building cool. After	S 580	cross reference F684 1. Cannot retroactively correct. R9 no longer resides at the facility. 2) All residents have the potential to be impacted by loss of cooling events during hot weather. The facility wide audits were conducted for all residents who have a current order for thickened liquids on 5/5/2025. DON in-serviced nursing staff on 4/30/24 through 5/2/24 for monitoring of signs and symptoms of heat related illness and initiated staff to monitor resident temperatures on every shift through 5/3/24 to also ensure the temperature was maintained below 81 degrees on other wings for the safety of all residents. The Quality Assurance Nurse monitors the par levels of thickened liquids on a routine basis to keep it above a 3-day supply, to ensure thickened liquid is readily available and on hand for all residents who have an order for thickened liquids which may include compromised residents. In addition, the thickened liquid is stocked in the kitchen with the Emergency Supplies and has a date of expiration of 4/2026. cont...	516/2025

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S 580	Continued From page 3 temperatures above 81 degrees were recorded for more than four hours, a Code Purple was enacted at 4:00 PM on 4/30/24. Upon request, the facility could not provide temperature monitoring/logs from 4/30/24 and prior to 4:30 PM on 5/1/24. From 4:30 PM on 5/1/24 until 10:30 AM on 5/2/24, hourly temperatures were recorded during 18 opportunities on unit 3A; of the 18 recorded temperatures, 16 of the temperatures recorded to be above 81 degrees. On 5/1/24 temperatures in the evening hours on Unit 3A reached over 90 degrees. Review of staff education provided on 4/30/24 and 5/1/24 revealed staff were educated to look for the following signs of heat related illness: high body temperature, red/hot/damp skin, fast pulse, headache/dizziness, nausea or vomiting and confusion/loss of consciousness. Actions for staff to take included: place cool, wet clothes on the skin, encourage light clothing, move to a cool area as able, offer plenty of fluids to drink and notify the provider of any change in a resident's condition. Resident #9 was admitted to the facility with diagnosis which included Parkinson's Disease, dementia, and dysphagia (swallowing disorder). The Minimum Data Set (an assessment tool) dated [redacted] documented the resident was assessed with a Brief Interview for Mental Status (BIMS) score of 3/15 which was indicative of impaired cognition. Resident #9 was assessed as being dependent on staff to complete most activities of daily living. The Nutrition Care Plan, initiated 7/27/23, documented the resident was at risk for dehydration. Interventions included staff were to observe for signs and symptoms of dehydration.	S 580	Cross reference F684 The root caused analysis was determined that the facility missed the opportunity to ensure each resident was provided care and treatment in accordance with professional standards of practice and were unable to keep up with the demand to cool the facility with insufficient oversight for observing the signs and symptoms to assess for acute distress of compromised residents at risk for dehydration. Staff also lacked the ability to monitor body heat related illness and elevated environment temperatures and provided insufficient hydration when temperatures rose above 81 degrees from 4/30/24 until 5/2/2024. Changes were made to the Code Purple protocol after the incident and corporate revised the procedure on 6/18/24 to ensure the at-risk residents or compromised residents were safe, comfortable during an emergency hot weather or planned/unplanned events related to loss of cooling. The Unit Managers and nursing supervisors were educated on documenting fluid intake on the ADL Flow Sheet and progress notes in the EMR system of compromised residents during an emergency incident. cont....	5/16/25

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S 580	Continued From page 4 The goal of the care plan was for Resident #9 to remain adequately hydrated as evidenced by good skin turgor, pink and moist mucous membranes and sufficient fluid intake. A Dietary Order dated 1/10/24 ordered the resident to receive honey thick liquids. A Physician Order dated 3/12/24 ordered staff to encourage thickened water intake during every shift. A Provider Note dated 4/24/24 documented Resident #9 seen by their provider and was assessed to be stable, afebrile and not in any acute distress. The resident was seen for a cough and prescribed Geri-tussin every 12 hours for 5 days. Review of Resident #9's electronic medical record (EMR) documented the resident received 240 millimeters of fluid with breakfast on 4/30/24; no additional fluids were documented. On 5/1/24, the resident was documented to have received 450 milliliters (15.2 ounces) of fluid across all shifts. No fluids were documented to have been provided on 5/2/24. Review of Resident #9's EMR revealed no progress notes were documented for the resident from the time they were seen by their provider on 4/24/24 until the morning of 5/2/24. A Nursing Progress Note dated [redacted] documented Resident #9 was found nonresponsive during care rounding. Vitals signs were obtained, and the resident's temperature was found to be 102 degrees. Orders were given to send the resident to the hospital for further evaluation and the resident was transported to	S 580	Cross reference F684 Education for monitoring body and environmental temperatures will be completed by 5/16/25 to all staff by the Quality Assurance Nurse and DON. Education will be conducted to the nursing staff by the Quality Assurance Nurse and DON to include assessment of residents on thickened liquids and notification to resident's family members/representatives related to acute change of condition to be recorded immediately in the EMR by 5/16/2025. 3) A facility wide education began on 4/30/25 by the DON, Maintenance Director and Quality Assurance Nurse to ensure all facility residents are not at risk for dehydration, heat related illness and/or Significant Change in Condition (CIC) following a Code Purple procedure in accordance with professional standards of practice. Education will continue to be completed by 5/16/2025, according to CDC guidance last updated on 6/25/24, along with the last revised Code Purple procedure dated 6/18/24 for at risk heat related illness. cont...	5/16/25

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S 580	Continued From page 5 the emergency room at 10:30 AM via emergency medical services (EMS). A Hospital Discharge Summary dated [redacted] documented Resident #9 was confused at baseline but was usually verbal. EMS staff reported there was no air conditioning at the facility where the resident resided. Resident #9 was given 1.5 liters of fluid from EMS and the emergency room collectively. The resident was admitted to the hospital for further evaluation and management of hyponatremia related to decreased oral intake with dehydration due to heat exhaustion. Resident #9 was treated for dehydration and hyponatremia which was resolved with IV hydration. During an interview on 3/31/25 at 1:16 PM, Registered Nurse Unit Manager (RNUM) #10 stated during the Code Purple, staff were educated to monitor residents for signs of heat exhaustion and dehydration and to round to provide additional hydration. They stated it was an "all hands-on deck situation" and there were no specific resident assignments to monitor for hydration. They stated fluids provided should be documented in the EMR. RNUM #10 reviewed Resident #9's EMR and stated there were no nursing progress notes throughout the Code Purple. They stated Resident #9 required encouragement and assistance to accept fluids. They stated Resident #9 had mumbled speech and could express some needs, however, would not have been someone who could voice complaint about the heat. They stated Resident #9 was found nonresponsive and with a fever on the morning of [redacted] and was sent out to the hospital. They reviewed Resident #9's hospital discharge summary and stated the labs obtained were significant for dehydration.	S 580	cross reference F684 4. The Quality Assurance Nurse will monitor the temperature log sheets and Code Purple Action Steps in the event of hot weather with loss of cooling, monthly x3 or until substantial compliance of 100% is achieved. Education added to new hire orientation to ensure staff are aware of the Code Purple Policy, along with compromised residents and those that are ordered thickened liquids. Results of audit will be presented to the QA committee monthly for further evaluation, recommendations and sustainability.	5/16/25

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S 580	Continued From page 6 During an interview on 3/31/25 at 1:59 PM, the Director of Nursing (DON) stated that nursing staff were educated during the Code Purple to monitor residents for signs of heat exhaustion or changes in condition and to provide additional fluids. They stated routine charting of hydration was not completed during the code. They stated additional education had not been completed with nursing staff in response to the Code Purple after it was cleared. They stated they had reviewed Resident #9's EMR's and noted there was a lack of documentation. They stated Resident #9 was at risk for dehydration due to their diagnoses. During an interview on 4/1/25 at 9:08 AM, Social Work Case Manager (SWCM) #5 stated they were Resident #9's assigned case manager. They stated Resident #9 had mumbled speech but could express their needs in a limited capacity. They stated they had started calling residents' family members/representatives on the morning of [redacted] to inform them of moving residents to another area of the building, however, residents were not moved, and Resident #9 was sent out to the hospital that morning. They stated Resident #9's family expressed concern to them about the resident being impacted by the heat but that by the time the resident returned from the hospital, the cooling system was functional again. During an interview on 4/1/25 at 2:04 PM, the Medical Director stated Resident #9 had a diagnosis of advanced Parkinson's Disease and was prescribed thickened liquids to prevent aspiration. They stated staff at the facility monitored the resident's hydration and encouraged fluids. They stated residents who were prescribed thickened liquids were at	S 580		5/16/25

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S 580	Continued From page 7	S 580		5/16/25

increased risk for dehydration because they did not receive as much hydration from thickened fluid intake. They stated they had reviewed Resident #9's EMR and noted that there was no nursing progress notes during the time the facility experienced increased temperatures on the unit. They stated it was important to encourage fluids and stay proactive in observing residents for any change that could indicate heat related symptoms. They stated when Resident #9 was sent to the hospital, the labs were indicative of dehydration and hyponatremia. The Medical Director stated Resident #9 had worsening encephalopathy and comorbidities which contributed to the change in their condition.

During an interview on 4/2/25 at 1:06 PM, Nurse Practitioner #24 stated they had been the primary care provider for Resident #9. They stated they had seen Resident #9 multiple times prior to the resident's hospitalization and the resident had been stable. They stated Resident #9 was at risk for dehydration and staff were to encourage fluids. They stated they went to assess Resident #9 on the morning of [redacted] after the nurse reported the resident had a fever and was nonresponsive. They stated the cooling units in the building had not been working for two days and the resident's room was very hot when they arrived. They stated they immediately called out for a cold compress and gave the order that the resident should be sent to the emergency room. They stated they did not don't recall any additional interventions implemented during the cooling system outage.

During an interview on 4/2/25 at 1:25 PM, the Safety and Security Director (SSD) stated they participated in a meeting following the Code Purple. They stated the facility had ample water

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S 580	Continued From page 8 and Gatorade to disperse to residents during the code, however, it was identified the need for additional need for thickened liquids/residents who required a different consistency was not taken into account. They stated it was identified that thickened liquids needed to be more available on the care units and not kept in storage in the kitchen. It was also identified that fluid intake should be documented in resident medical charts.	S 580		5/16/25

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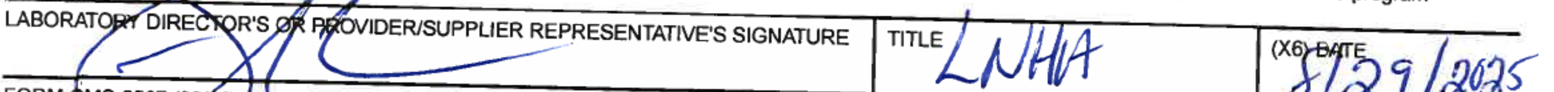
F0000	INITIAL COMMENTS On 7/15/2025, 7/16/2025, 7/17/2025, 7/18/2025, 7/21/2025, 7/22/2025, 7/23/2025, 7/24/2025 and 7/25/2025 a recertification survey was conducted at this facility by the Office of Health Care Quality. The facility's licensed bed capacity is 318 and the census was 216 0n 7/15/2025.The Survey had a sample of 35 residents. Survey activities consisted of review of medical records, interviews with residents,, family members, facility staff, ombudsman, and observations of residents and staff practices. A review of facility polices was also conducted. Additionally, 16 facility reported incidents: 330830, 330832, 330834, 330867, 330871, 330872, 330873, 330874, 330875, 30876, 330877, 330878, 330879, 330880, 330881, 330882 and 1 complaint 330876 were investigated. The facility was determined not to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The following deficiencies are a result of this survey: F 0550 Resident Rights/Exercise of Rights F 0558 Reasonable Accommodations Needs/Preferences F 0605 Right to be Free from Chemical Restraints F 0656 Develop/Implement Comprehensive Care Plan	F0000	F550 The facility staff failed to ensure a dignified existence was maintained due to R #123 fitted sheet was heavily soiled and the mattress was half covered. The heavily soiled linen was discarded when resident #123 allowed staff to change linen. Although all of Charlotte Hall Veterans Service residents who refuse hygienic care and linen changes have the potential to be impacted by this deficient practice, no other residents have been identified as being impacted. Implement measures and systemic changes: • On August 28, 2025, the Director of Health Services (DHS) in-serviced the Assistant Director of Health Services (ADHS), Unit managers (UM) (Registered Nurses RN x4 and Licensed Practical Nurses LPN x2), Director of MDS Coordinator RN, Evening shift supervisor RN, LPN Electronic Medical Records Trainer, Quality Assurance RN, Infection Preventionist RN, and 2 Clinical Competency Coordinator RN (CCC) on addressing resident's refusal of care to include: the geriatric nursing assistants (GNA) should notify the nurse of all refusals of care (including changing soiled linen), then the nurse and GNA should ask/offer (at different times) the resident to allow them to provide care/linen changes. • Starting August 29, 2025, the ADHS/UM/CCC/RN will utilize the written in-services provided by the DHS to educate the clinical team: RN, LPN, and GN. This will be completed by October 1, 2025. • Residents' rights will continue to be reviewec during the new hire orientation.	10/01/2025

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 reverse for further 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 LNHA | (X6) DATE 8/29/2025

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F0000	Continued from page 1 F 0677 ADL Care Provided for Dependent Residents F 0761 Label/Store Drugs and Biologicals F 0812 Food Procurement, Store/Prepare/Serve-Sanitary F 0880 Infection Prevention and Control	F0000	F550 cont'd	10/01/2025
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and	F0550	• Facility will monitor compliance by completing the "Compliance Rounds Audit Tool". The Compliance Rounds Audit Tool identifies if linen is clean and mattress is covered. • Starting September 1, 2025, the UMs/ADHS/RN will do 5 random room audits per nursing unit each weekday and the weekend shift supervisors will do 10 random room audits per day and document finding on the compliance rounds audit tool. • If linen is soiled or bed not properly made during the room audits, the auditor will notify the assigned charge nurse and G.N.A for correction. • Evaluation of performance: • Compliance Rounds Audit tool to be completed as described above x 3 months with findings evaluated in the monthly Quality Assurance and Performance and Improvement meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215161	A. BUILDING B. WING	**07/25/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlotte Hall Veterans Home	**29449 CHARLOTTE HALL ROAD , CHARLOTTE HALL, Maryland, 20622**

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F0550 SS = D

Continued from page 2
to be supported by the facility in the exercise of his or her rights as required under this subpart.

This REQUIREMENT is NOT MET as evidenced by:

Based on observation and interview it was determined that the facility staff failed to ensure a dignified existence was maintained as evidenced of a resident's fitted sheet being heavily soiled and the mattress was half covered. This deficient practice was evidenced in 1 (#123) resident observed with a compromised dignified existence during the recertification survey.

The findings include:

On 07/16/25 at 10:28 am the surveyor observed Resident #123 fitted sheet with large spots of a green substance and half of the mattress was exposed. LPN #14 was in the room giving medications to the resident's roommate. Afterwards, LPN #14 walked past Resident #123 and left the room without offering the resident any assistance. The surveyor checked the resident electronic health record to see if there was documentation to verify assistance was offered to the resident and refused.

On 07/23/25 at 11:39 am during an interview with LPN Unit Manager #20 he/she verbalized the resident tries to be independent as possible and is resistant to care and that should be care planned. The staff allows [redacted] to meet [redacted] needs on [redacted] own. The surveyor asked if a resident is resistant to care sometimes should the staff at least offer to provide assistance. LPN Unit Manager #20 verbalized, yes.

F0550 — Plan of correction (Completion date: 10/01/2025):

F558
Facility failed to ensure residents (80, #90, #125, #190, #201)
had their call lights within reach.
Immediate actions taken to resolve issue: the unit manager
completed rounds on the unit to
ensure proper placement of call lights when notified by surveyor on 7/16/2025.
All the residents at the facility have the potential to be impacted
by this deficient practice.
Implement measures and systemic changes:
• Director of Health Services reviewed policy, Nursing: Patient/Residents Rights,
Needs/Preference for in-service guidance and review with clinical leadership team.
• On August 28, 2025, the Director of Health Services (DHS)
in-serviced the Assistant
Director of Health Services (ADHS),
Unit managers (UM)
(Registered Nurses RN x4 and
Licensed Practical Nurses LPN x2), Director of MDS
Coordinator RN, Evening shift
supervisor RN, LPN Electronic Medical Records
Trainer, Quality Assurance RN, Infection Preventionist
RN, and 2 Clinical Competency
Coordinator RN (CCC) on
ensuring proper placement of the call lights for residents
to request assistance as needed.

• Starting August 29, 2025, the ADHS/UM/CCC/RN will utilize the written in-services
provided by the DHS to educate the clinical and non-clinical
staff members. This will be
completed by September 26, 2025.
• Any staff member on FMLA or PTO will receive education upon their return to work.
• Accommodation of needs with call light accessibility will continue to be reviewed during
the new hire orientation.
Facility will monitor compliance by completing
the "Compliance Rounds Audit Tool". The
Compliance Rounds Audit Tool identifies if the call
light is within easy reach.

F0558 SS = E

Reasonable Accommodations Needs/Preferences

CFR(s): 483.10(e)(3)

§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.

This REQUIREMENT is NOT MET as evidenced by:

Based on observations and interviews it was determined that the facility staff failed to ensure residents had their call bell within reach to notify the staff when assistance was needed, This deficient practice was evidenced in 5 (#80, #90, #125, #190, #191, #201) residents observed without their call bells during the initial observation rounds during the recertification survey.

F0558

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F0558 SS = E	Continued from page 3 The findings include: During the surveyor's initial observation rounds on 07/16/25 at 9:49 am the surveyor observed Resident #80 call bell behind the bed. Geriatric Nursing Assistant (GNA) # 10 confirmed the surveyor's findings. At 10:08 am the surveyor observed Resident #191 call bell hanging off the left side of the bed close to the floor, which was not in reach of the resident. At 10:09 am the surveyor observed Resident #125 call bell hanging on the right side of the bed. GNA #12 confirmed the surveyor's findings. At 10:12 am Resident #90 was sitting in their wheelchair on the L side of the bed and the call bell was on the right side of the bed on the wall. 10:52 am Resident #201 call bell was hanging from the wall port on the R side of the bed and was not in reach of the resident. GNA #10 confirmed the surveyor's findings. 11:15 am Resident #190 was up in the chair near the window, the call bell was on the wall near the foot of the bed, which was not in the resident's reach. 07/17/2025 9:40 AM During an interview Registered Nurse (RN) #16 he/she verbalized the call bell should always be within reach of the resident and the staff should let the resident know where it is located. Each time they go into a resident's room they should check to make sure the resident has the call bell.	F0558	F558 cont'd • Starting September 2, 2025 the UMs/ADHS/RN will do 5 random room audits per nursing unit each weekday shift supervisors will do 10 random room audits per day and document finding on the compliance rounds audit tool. • If the call light is not within easy reach, the auditor will immediately reposition the call light to be within easy reach. Auditors will notify charge nurse assigned of their findings. Evaluation of performance: - Compliance Rounds Audit tool to be completed as described above x 3 months with findings evaluated in the monthly Quality Assurance and Performance Improvement meetings. Corrective Actions to be completed by 10/01/2025.	10/01/2025
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse,	F0605		

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F0605 SS = D	Continued from page 4	F0605		10/01/2025

Continued from page 4
neglect, misappropriation of

resident property, and exploitation as defined in this subpart. This includes but is

not limited to freedom from corporal punishment, involuntary seclusion and any

physical or chemical restraint not required to treat the resident's medical

symptoms.

§483.12(a) The facility must-. . .

§483.12(a)(2) Ensure that the resident is free from . . . chemical restraints

imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.

. . . .

§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

(i) Anti-psychotic;

(ii) Anti-depressant;

(iii) Anti-anxiety; and

(iv) Hypnotic.

§483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-

(1) In excessive dose (including duplicate drug therapy); or

(2) For excessive duration; or

(3) Without adequate monitoring; or

(4) Without adequate indications for its use; or

(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

Provider's Plan of Correction (F0605) — Completion date: 10/01/2025

FTAG 605 D
Facility failed to ensure resident #80 had a gradual dose reduction when no behaviors noted for 5 months.
Immediate actions taken to resolve issue:
Resident #80 was reviewed in the weekly GDR meeting on 8/7/25, with a new order written to reduce the Seroquel from 25mg to 12.5mg at bedtime. Ongoing behavioral monitoring is noted.
All the residents receiving antipsychotic medications at the facility have the potential to be
impacted by this deficient practice.
Implement measures and systemic changes:
• Director of Health Services reviewed the policy, Chemical Restraints Elimination for in service guidance with clinical team.
• On August 28, 2025, the Director of Health Services (DHS) in-serviced the Assistant Director of Health Services (ADHS), Unit managers (UM) (Registered Nurses RN x4 and Licensed Practical Nurses LPN x2), Director of MDS Coordinator RN, Evening shift supervisor RN, LPN Electronic Medical Records Trainer, Quality Assurance RN, Infection Preventionist RN, and 2 Clinical Competency Coordinator RN (CCC) on ensuring documentation of all behaviors are noted on the monitoring log.
• Starting August 29, 2025, the ADHS/UM/CCC/RN will utilize the written in-services
provided by the DHS to educate the RNs and LPNs. This will be completed by September 26, 2025.
• Any licensed partners on FMLA or PTO will receive education upon their return to work.
• DHS will review findings of this citation with the Psychiatric NPs to review gradual dose reduction requirements when no behaviors are documented. A copy of the policy, Chemical Restraint Elimination will be given to Psychiatric NPS. This will be completed by September 26, 2025.
Facility will monitor compliance by completing the
• An initial audit will be completed to review all residents receiving antipsychotic medications, the last dose change, and the last GDR. This will be recorded on the Antipsychotic GDR Audit Tool. DHS will complete this initial audit by September 8, 2025.

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F0605 SS = D	Continued from page 5 (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview it was determined that the facility staff failed to attempt to decrease a resident's psychotropic medication when they had no documented behaviors for at least five months. This deficient practice was evidenced in 1(#80) of 1 resident records reviewed for gradual dose reductions of psychotropic medications during the recertification survey.	F0605	F605 Cont'd • Ongoing, with each GDR monthly meeting which is held every 1st Thursday of month, the Antipsychotic GDR Audit Tool will be completed to include current antipsychotic medications, the last dose change, the last GDR, and presence of behaviors. Evaluation of performance: • Antipsychotic GDR Audit tool to be completed as described above monthly x 3 months with findings evaluated in the monthly Quality Assurance and Performance Improvement meetings.	10/01/2025

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F0605 SS = D	Continued from page 6 The findings include: On 07/22/25 at 9:03 am the surveyor reviewed Resident #80 Psychiatric notes dated 12/19/24, 03/20/25, and 06/19/25. The note dated 12/19/24 indicated the resident had a failed gradual does reduction (GDR) attempt in 11/24. According to Psychiatric Nurse Practitioner (NP) #21 note the resident displayed agitation, the use of profane language, and the inability to adhere to safety precautions when the psychotropic medication was decreased. The notes dated 03/20 and 06/19 indicated a GDR was not indicated. A review of the resident's behavioral monitoring documentation dated 03/01/25 – 07/21/25 the staff documented the resident did not observe any behavioral problems from the Resident #80 before and after administration of the psychotropic medication Quetiapine 25 mg. On 07/23/25 at 8:43 am during an interview with Psychiatric NP #21 the surveyor asked when the last time a GDR was done with Resident #80 psychotropic medication. He/she verbalized during the last GDR his/her behavior started to show up. Cursing at the staff, and agitation was only when [redacted] was off the medication. The GDR was done in November. A GDR was not attempted since November it was on their list to complete another GDR. Their goal in psychiatry is not to keep residents on the medication but to try the lowest dose of the medication. If a patient has been stable for a while a GDR can be attempted.	F0605	FTAG 656 D Facility failed to ensure resident #74 had a care plan implemented due to dental concerns. Immediate actions taken to resolve issue: Resident #74 had a dental care plan implemented on 7/23/25. All the residents with natural teeth have the potential to be impacted by this deficient practice. Implement measures and systemic changes: • Director of Health Services reviewed policy, Care Plan, for in-service guidance with clinical team. • On August 28, 2025, the Director of Health Services (DHS) in-serviced the Assistant Director of Health Services (ADHS), Unit managers (UM) (Registered Nurses RN x4 and Licensed Practical Nurses LPN x2), Director of MDS Coordinator RN, Evening shift supervisor RN, LPN Electronic Medical Records Trainer, Quality Assurance RN, Infection Preventionist RN, and 2 Clinical Competency Coordinator RN (CCC) on care plan updates for dental concerns. • MDS Coordinator Director to in-service other MDS coordinators regarding updating/initiating care plans when quarterly assessment reviews and significant changes assessments are being completed with dental care triggers. In-service to be completed by September 12, 2025. • Starting August 29, 2025, the ADHS/UM/CCC/RN will utilize the written in-services provided by the DHS to educate the RN & LPN. This will be completed by September 26, 2025. • Any licensed nurse on FMLA and PTO will receive the education upon their return to work. • An initial audit of all residents that were seen by the dentist during the past 6 months will have their care plans reviewed to ensure a dental care plan was implemented. This will be completed by the DHS by September 19, 2025. Immediate correction will be completed by the DHS at the time of the audit. Facility will monitor compliance by completing the Dental care plan audit tool. • Starting September 20, 2025, with each dental appointment, the residents' care plans will be reviewed by the UM/ADHS/RN/DHS to ensure the care plan is in place and up to date. This audit will be noted on the dental care plan audit tool. • If no care plan is noted, a dental care plan will be initiated immediately.	10/01/2025
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F0656		

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F0656 SS = D	Continued from page 7 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview it was determined that the facility staff failed to initiate a dental care plan for a resident who had dental concerns. This deficient practice was evidenced in 1 (#74) of 1 resident reviewed for dental concerns during the recertification survey. The findings include: On 07/17/2025 at 9:30 am while speaking with Resident #74 responsible party/emergency contact they verbalized the resident had a lot of issues with his/her bottom teeth and they were supposed to get the resident back to the dentist. On 07/21/25 at 10:15 am a review of Resident #74 electronic health record (EHR) revealed the resident did not have a dental care plan although the facility	F0656	FTAG 656 D (con't) Evaluation of performance: • Dental Care plan Audit tool to be completed as described above monthly x 3 months with findings evaluated in the monthly Quality Assurance and Performance Improvement meetings. Corrective Actions to be completed by 10/1/25.	10/01/2025

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F0656 SS = D	Continued from page 8 staff was aware the resident had dental concerns. The surveyor received a copy of an appointment request dated 07/07/25 for the resident related to dental pain. On 07/21/2025 at 3:03 pm during an interview with the Director of Nursing (DON) the surveyor reported the resident did not have a dental care plan. The DON verbalized the Unit Managers should make sure the care plans are completed. MDS helps but ultimately the nurses are responsible for completing the care plans.	F0656		10/01/2025
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and interviews it was determined that the facility staff failed to provide a resident with a shower for several months and failed to consistently provide a resident with a shower. This deficient practice was evidenced in 2 (#4 & #80) resident records reviewed for ADL care during the recertification survey. The findings include: During observation rounds on 07/17/25 at 10:57 AM the surveyor asked Resident #4 when the last time he/she had a shower. The resident verbalized he/she has not had a shower in several months. There was a strong odor of urine in the resident's room. On 07/21/25 at 10:45 AM a review of the Shower Schedule for the residents on 2B revealed Resident #80 was scheduled to have a shower on Monday and Thursday. The facility's documentation revealed the resident had not received a shower twice a week. There was no documentation to verify the resident received a shower on 07/17, 7/03, 06/26, 6/12, 06/05, and 06/02. There was no documentation to indicate the resident refused a shower. The surveyor went to Resident #4 room on 07/23/2025 at 11:06 AM and asked had he/she had a shower. The resident verbalized the staff told [redacted] they don't have a wheelchair to take [redacted] to get a shower. On 07/23/25 at 11:25 AM during an interview with	F0677	FTAG 677D Facility failed to ensure residents #4 and #80 received their showers per schedule nor was there documentation to indicate refusals. Immediate actions taken to resolve issue: Resident #80 received a shower on 7/25. Resident #4 already care planned about preference of bed bath and often refuses to get out of bed. All the residents at the facility have the potential to be impacted by this deficient practice. Implement measures and systemic changes: • On August 28, 2025, the Director of Health Services (DHS) in-serviced the Assistant Director of Health Services (ADHS), Unit managers (UM) (Registered Nurses RN x4 and Licensed Practical Nurses LPN x2), Director of MDS Coordinator RN, Evening shift supervisor RN, LPN Electronic Medical Records Trainer, Quality Assurance RN, Infection Preventionist RN, and 2 Clinical Competency Coordinator RN (CCC) on ensuring showers are given as scheduled and if refusals noted, nurse to follow up with resident, attempt to get them to comply with shower, if not, document refusals in progress notes and GNA to document in Care Assist. • Starting August 29, 2025, the ADHS/UM/CCC/RN will utilize the written in-services provided by the DHS to educate the RN, LPN, and GNAs that provide direct patient care. This will be completed by September 26, 2025. • ADL Care and documentation will continue to be reviewed during the new hire orientation. Facility will monitor compliance by completing the "ADL Audit Tool". The ADL Audit Tool reviews the shower schedule, verify shower given, and documentation is completed for refusals. • Starting September 2, 2025, the UMs/ADHS/RN will review all showers scheduled on their assigned nursing unit each weekday and the weekend shift supervisors will review the showers assigned for the weekend, and document finding on the ADL audit tool. To be done weekly x4, 10 random residents per unit, per monthly x2. • Findings will also be reviewed during the weekday clinical meeting. • Any non-compliance with documentation and follow-through will be addressed with the assigned partners immediately. Evaluation of performance: • ADL Audit tool to be completed as described above monthly x 3 months with findings evaluated in the monthly Quality Assurance and Performance Improvement meetings. Corrective Actions to be completed by 10/1/25.	

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F0677 SS = D	Continued from page 9 Geriatric Nursing Assistant (GNA) #17 the surveyor asked what the process is for documenting whether a resident had a shower or bed bath. She/he verbalized the residents choose what ADL care they prefer, and they document in the computer. There is a place to document if a resident refuses a shower or bed bath. If a resident consistently refuses, the nurse is made aware. On 07/23/2025 at 11:18 AM the surveyor reviewed the Bath Schedule for the residents on 3B; Resident #4 was scheduled to receive a shower on Wednesday and Saturday. At 12:35 PM a review of Resident #4 electronic health record (EHR) documentation of the resident's type of bathing received, there was no documentation to verify the resident had a shower from 04/01/25 - 07/22/25.	F0677		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interview it was determined that the facility staff failed to: 1.)	F0761	FTAG 761 D Facility failed to ensure proper temperature storage of medications to preserve medication integrity and properly label multidose medications with the complete date. Immediate action taken: all items identified during the survey were immediately discarded and reordered. Although all residents have the potential to be impacted by this deficient practice, none were identified. Implement measures and systemic changes: • Director of Health Services reviewed policy, Medication Storage in the Healthcare Centers for in-service guidance with clinical leadership team. • On August 28, 2025, the Director of Health Services (DHS) in-serviced the Assistant Director of Health Services (ADHS), Unit managers (UM) (Registered Nurses RN x4 and Licensed Practical Nurses LPN x2), Director of MDS Coordinator RN, Evening shift supervisor RN, LPN Electronic Medical Records Trainer, Quality Assurance RN, Infection Preventionist RN, and 2 Clinical Competency Coordinator RN (CCC)) on medication storage, dating multidose medications/supplements, and discarding those that are not kept at proper temperature or those that are improperly labeled with a legible opened date. . • Starting August 29, 2025, the ADHS/UM/CCC/RN will utilize the written in-services provided by the DHS to educate the RN, LPN, and Certified Medication Assistants (CMA)s that provide medication administration. This will be completed by September 26, 2025. • Any licensed staff and medication aides on FMLA or PTO will receive the education upon their return to work. • Medication Storage will continue to be reviewed during the new hire orientation. Facility will monitor compliance with securing the unattended medication cart. • Starting September 2, 2025, the night shift charge nurses on each unit will complete the medication cart audit tool every Sunday and Wednesday to identify proper medication storage. • Any deficiency will be addressed immediately. Evaluation of performance: • Medication Cart Audit tool to be completed as described above x 3 months with findings evaluated in the monthly Quality Assurance and Performance Improvement meetings. Corrective Actions to be completed by 10/1/25.	10/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215161	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/25/2025
NAME OF PROVIDER OR SUPPLIER **Charlotte Hall Veterans Home**		STREET ADDRESS, CITY, STATE, ZIP CODE **29449 CHARLOTTE HALL ROAD , CHARLOTTE HALL, Maryland, 20622**	

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F0761 SS = D	Continued from page 10 ensure proper temperature storage of medications to preserve medication integrity and 2.) properly label multi-dose medications with the complete date that the medication was opened. This was true for 2 of 7 medication carts reviewed during the annual survey. The findings include: 1. On 7/22/2025 at 10:52 AM, a medication storage observation was conducted on the first floor accompanied by Nurse #23. Observation of the medication cart for the High Hall revealed 2 unopened insulin pens that were clearly marked to refrigerate until opened in the medication cart. The surveyor verified that the insulin pens were supposed to be refrigerated until open with employee #23. Nurse #23 acknowledged surveyors' findings discarded the insulin pens. 2. On 7/22/25 at 1:58 PM, the surveyors observed an illegible handwritten open date on a multidose solution bottle located inside the medication cart. An interview with LPN #8 indicated that she could not decipher the date on the bottle as it had been worn away. Additionally, LPN #8 was not aware of the correct procedures to follow when the open date label was missing from the multi-use solution bottle. On 7/23/25 at 9:30 AM, the Administrator disclosed that LPN #8 had reported the concerns during the daily meeting, and the appropriate procedures were reiterated, which included discarding the open bottle with missing an open date label and properly dated all other multi-dose medications when opened.	F0761	F812 A) The CDM (Certified Dietary Manager) took the Refrigerator #4's temp & documented it at 5:15am temperature on 7/15/25 read as 39 degrees Fahrenheit, when taken during the walk through the temperature #4, it read over 41 degrees Fahrenheit from the hanging thermometer, therefore, the CDM placed the #4 refrigerator out of order as reflected on the temperature log sheet. The CDM also corrected and removed eyeglasses placed on top of dishwasher immediately along with removing the 30-ounce personal drinking container on top of dishwasher. The CDM immediately placed an Out of Order Sign on the hand wash sink in the dish washer area and corrected and filled the empty towel dispenser along with soap dispenser same day of walk through. The CDM also filled the paper towel dispenser located next to the hand sink near the walk-in fridge of the prep area of the kitchen the same day of walk through. The CDM immediately referred to the pull date log and labeled the raw chicken on the long silver tray in reference to the three blue bags of raw chicken thawing for date to be used.In addition, CDM discarded the egg salad temped after being made same day stating the egg salad was rechecked via temperature, however, was unable to continue through the cooling process (under two hours before the temperature was taken again). CDM also discarded the deli meat sandwiches immediately after walking through. No residents were affected and all kitchen staff in-serviced began on 8/28/2025 by the CDM and Administrator.	10/01/2025
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local	F0812		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215161	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/25/2025

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F0812 SS = E	Continued from page 11 laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations of the facility's kitchen and food services, it was determined that the facility failed to maintain food service equipment in a manner that ensures safe and sanitary food service operations. This was identified during multiple observations of kitchen food service operations. The findings include: On 7/17/25 at 10:33 AM a tour of the kitchen was conducted which revealed: - A pair of eyeglasses placed on top of dishwasher - One 30-ounce personal drinking container on top of the dishwasher - An empty hand paper towel dispenser, one empty soap dispenser located at the hand wash sink in dish washer area - An empty paper towel dispenser located next to the hand sink near the walk-in fridge of the food prep area of the kitchen. On 7/15/25 at 11:35 AM a continued tour of the walk-in refrigerator revealed: - one long silver tray containing three large blue bags of raw chicken without a label noting its thaw date. On 7/15/25 at 11:45 AM Refrigerator #4's internal temperature taken from the hanging thermometer read 50 degrees Fahrenheit; the temperature viewed again ten	F0812	F812 cont'd B) The CDM (Certified Dietary Manager) and Administrator completed a walk through on 7/17/2025 through the kitchen to ensure the kitchen food service equipment is in good working manner and to ensure safe and sanitary food service operations are maintained, labeled properly and served in accordance with professional standards for food service safety. No residents were affected. All corrected actions to be completed by 10/1/2025. C) The root cause analysis determined that staff and CDM failed to follow policy and procedure for food safety and sanitation, as evidence and failed to maintain food service equipment in a manner that ensures safe and sanitary food service operations. All kitchen and/or dietary staff received education that began on 8/28/25, including the CDM by the Administrator. D) The CDM and/or assistant to CDM along with the administrator will continue to conduct audits to ensure the kitchen food service equipment is in good working manner and to ensure safe and sanitary food service operations are maintained, labeled properly and served in accordance with professional standards for food service safety. The audits will be completed daily, or once 100% compliance is achieved for five consecutive days. The audits will continue to occur 5x a week for 3 consecutive weeks, or until 100% compliance is achieved for 3 consecutive months. Audit findings will be reported to the QAPI committee and will monitor monthly log reports.	10/01/2025

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F0812 SS = E	Continued from page 12 minutes later and it read 48 degrees Fahrenheit. Refrigerator #4 contained a tray of egg salad dated 7/15/25 and several snack trays (including dozens of deli meat sandwiches) Certified Dietary Manager, (CDM) assessed the egg salad's temperature with her thermometer which read 56 degrees Fahrenheit. The CDM trashed all the deli meat sandwiches and all of the egg salad.	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F0880	FTAG 880 D Facility failed to ensure infection control procedures were maintained properly in four areas: multi-use equipment was not properly sanitized after each use, proper signage for transmission based precautions, urinary drainage bag port was on floor, and oxygen tubing was on floor. Immediate action taken: the Anti germicidal wipe was placed on the medication cart for glucometer meter cleaning, the EBP signage was removed while the contact isolation signage remained, the urinary drainage bag and oxygen tubing were replaced immediately once identified. Although all residents have the potential to be impacted by this deficient practice, none were identified. Implement measures and systemic changes: • Director of Health Services reviewed policies, Infection Control: Glucometer Cleaning and Disinfecting and Transmission Based Isolation Precautions for in-service guidance with clinical leadership team. • On August 28, 2025, the Director of Health Services (DHS) in-serviced the Assistant Director of Health Services (ADHS), Unit managers (UM) (Registered Nurses RN x4 and Licensed Practical Nurses LPN x2), Director of MDS Coordinator RN, Evening shift supervisor RN, LPN Electronic Medical Records Trainer, Quality Assurance RN, Infection Preventionist RN, and 2 Clinical Competency Coordinator RN (CCC) on infection control and prevention measures related to glucometer cleaning, proper isolation signage, drainage bags placement, and oxygen tubing placement. • Starting August 29, 2025, the ADHS/UM/CCC/RN will utilize the written in-services provided by the DHS to educate the RN, LPN, and Certified Medication Assistants (CMA)s that provide direct patient care. This will be completed by September 26, 2025. • Infection control will continue to be reviewed during the new hire orientation. • Any clinical partner on FMLA or PTO will receive the education upon their return to work. The facility will monitor compliance with the identified infection control protocols utilizing the compliance rounds audit tool to capture drainage bag, proper isolation signage, and oxygen bag placement. The glucometer cleaning checklist will be utilized to ensure nurses are cleaning the meter properly.	10/01/2025

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F0880 SS = D	Continued from page 13 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, infection control policy review, and interview with staff, it was determined that the facility: 1) failed to ensure that multi-use equipment was properly sanitized after each use and 2) failed to provide accurate transmission based precautions signage outside resident rooms. This was evident for 1 of 4 medication carts and 2 out of 5 residents' doors observed during the annual survey. It was also observed that the facility staff failed to maintain infection control practices for a resident who had a urinary drainage bag as evidenced by the drainage port being on the floor with the tubing being heavily soiled, and a resident's oxygen tubing was on the	F0880	FTAG 880 D • Starting September 2, 2025, the compliance rounds audit tool will be completed weekly on every nursing unit to audit all residents with foley bags, residents with oxygen tubing, and residents on isolation. Any non-compliance will be addressed immediately. To be done weekly x4, then monthly x2. • The Glucometer cleaning checklist will be completed on at least 7 nurses per week. Any non-compliance areas will be addressed/ corrected immediately, weekly x4, then monthly x2. • Any deficiency will be addressed immediately. Evaluation of performance: • The compliance audit tool and the glucometer cleaning checklist to be completed as above-described x 3 months with findings evaluated in the monthly Quality Assurance and Performance Improvement meetings. Corrective Actions to be completed by 10/1/25.	10/01/2025

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F0880 SS = D	Continued from page 14 floor. This deficient practice was evidenced in 2 (#107, #209)) of 5 residents observed with a drainage bag or oxygen therapy during the recertification survey. The findings include: On 7/22/25 at 2:25 PM, an interview with Licensed Practical Nurse (LPN # 9) disclosed that the Freestyle Libre 2 was cleaned after use with 70% isopropyl alcohol wipes after each use. At 3:00 PM, an observation was made of a contact precaution sign and an enhanced barrier precaution signage posted outside Room B112. On 7/23/25 at 9:00 AM, the surveyors reviewed the Glucometer Cleaning and Disinfecting policy and procedures, which stated that multi-use equipment are disinfected by using the Environmental Protection Agency (EPA) approved germicidal/virucidal disinfectant wipes before and after each patient use. On 7/24/25 at 9:30 AM, the Administrator and the Director of Nursing (DON) acknowledged the concern regarding the disinfection of multi-use equipment and the discrepancies for enhanced barrier precaution and transmission based precaution signage posted on residents' rooms. The DON confirmed that multi-use equipment should be cleaned with disinfecting wipes after each use and that the highest level of transmission based precaution signage must be displayed in the residents' rooms. During an interview on 7/24/25 at 11:05 AM, Infection Preventionist #1 confirmed the facility's expectations regarding the posting of transmission based precaution signage in the residents' rooms. She stated that the highest level of enhanced barrier precaution signage should be displayed in the residents' rooms. However, at 2:00 PM, the surveyors noted both contact precaution and enhanced barrier precaution signage remained posted outside Room B112. During the exit conference held on July 25, 2025 at 10:00 AM, the Assistant Administrator (AA) #7 reported that one resident in Room B112 was on contact precautions while the other resident was on enhanced barrier precautions, which explained the presence of both signs on the residents' room. AA #7 confirmed that in the absence of additional information, an individual entering the room would be unaware of which precautions to apply to which resident.	F0880		

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F0880 SS = D	Continued from page 15 During observation rounds on 07/16/25 at 9:57 AM the surveyor observed Resident #209 urinary drainage bag emptying port on the floor and the tubing was heavily soiled. The tubing was dated 06/25/25. Geriatric Nursing Assistant (GNA) #12 confirmed the surveyor's findings. The surveyor asked GNA #12 why the drainage port was on the floor and the tubing was soiled. GNA #12 verbalized being unsure, but they would make sure the drainage bag would be changed. At 10:28 AM the surveyor observed Resident #107 oxygen concentration on, but the resident was not in the room. Under further observation, the resident's nasal cannula tubing was on the floor and still attached to the oxygen concentrator. The water container for humidification was labeled 07/07/25. Licensed Practical Nurse (LPN) #14 confirmed the surveyor's findings and verbalized that the resident only uses oxygen therapy at night. On 07/23/2025 at 11:47 AM during an interview with LPN Unit Manager #20 the surveyor reported their findings during observation rounds. LPN Unit Manager #20 verbalized the nasal cannula should be placed in a Ziplock bag when not in use and sterile water should be changed weekly. The surveyor reported the sterile water was labeled 07/07 and the findings were observed on 07/16 which was nine days after the original date of use. LPN Unit Manager #20 reported the staff should have turned the machine off while not in use.	F0880		

Maryland State Department of Health

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S0000	Initial Comments On 7/15/2025, 7/16/2025, 7/17/2025, 7/18/2025, 7/21/2025, 7/22/2025, 7/23/2025, 7/24/2025 and 7/25/2025 a recertification survey was conducted at this facility by the Office of Health Care Quality. The facility's licensed bed capacity is 318 and the census was 216 0n 7/15/2025.The Survey had a sample of 35 residents. Survey activities consisted of review of medical records, interviews with residents,, family members, facility staff, ombudsman, and observations of residents and staff practices. A review of facility polices was also conducted. Additionally, 16 facility reported incidents: 330830, 330832, 330834, 330867, 330871, 330872, 330873, 330874, 330875, 30876, 330877, 330878, 330879, 330880, 330881, 330882 and 1 complaint 330876 were investigated. The facility was determined not to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The following deficiencies are a result of this survey:	S0000	Cross Referenced to CMS FTAGS, F550 F558 F656, F761, F812 and F880	10/01/2025
S0580	Nursing Services - Care 24 Hours a Day CFR(s): 10.07.02.18 C .18 Nursing Services.	S0580		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE LNHA | (X6) DATE 8/29/2025

STATE FORM

Maryland State Department of Health

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S0580	Continued from page 1 C. Nursing Care 24 Hours a Day. The administrator shall employ sufficient and satisfactory licensed nursing service personnel and support personnel to: (1) Be on duty 24 hours a day; (2) Provide appropriate bedside care; and (3) Ensure that a resident: (a) Receives treatments, medications, and diet as prescribed; (b) Receives rehabilitative nursing care as needed; (c) Receives proper care to prevent pressure ulcers and deformities; (d) Is kept comfortable, clean, and well-groomed; (e) Is protected from accident, injury, and infection; (f) Is encouraged, assisted, and trained in self-care and group activities; and (g) Receives prompt and appropriate responses to requests for assistance. This LICENSURE REQUIREMENT is NOT MET as evidenced by: See CMS 2567 F677	S0580	Cross Reference 2567 F677 FTAG 677D Facility failed to ensure residents #4 and #80 received their showers per schedule nor was there documentation to indicate refusals. Immediate actions taken to resolve issue: Resident #80 received a shower on 7/25. Resident #4 already care planned about preference of bed bath and often refuses to get out of bed. All the residents at the facility have the potential to be impacted by this deficient practice. Implement measures and systemic changes: • On August 28, 2025, the Director of Health Services (DHS) in-serviced the Assistant Director of Health Services (ADHS), Unit managers (U (Registered Nurses RN x4 and Licensed Practical Nurses LPN x2), Director of MDS Coordinator RN, Evening shift supervisor RN, LPN Electronic Medical Records Traine Quality Assurance RN, Infection Preventionist RN, and 2 Clinical Competency Coordinator RN (CCC) on ensuring showers are given as scheduled and if refusals noted, nurse to follow up with resident, attempt to get them to comply with shower if not, document refusals in progress notes and GNA to document in Care Assist. • Starting August 29, 2025, the ADHS/UM/CCC/RN will utilize the written in-services provided by the DHS to educate the RN, LPN, and GNAs that provide direct patient care. This will be completed by September 26, 2025. • ADL Care and documentation will continue to be reviewed during the new hire orientation. Facility will monitor compliance by completing the "A Audit Tool". The ADL Audit Tool reviews the shower schedule, verify shower given, and documentation is completed for refusals. • Starting September 2, 2025, the UMs/ADHS/RN will review all showers scheduled on their assigned nursing unit each weekday and the weekend shift supervisors will review the showers assigned for the weekend and document finding on the ADL audit too To be done weekly x4, 10 random residents per unit, per monthly x2. • Findings will also be reviewed during the weekday clinical meeting. • Any non-compliance with documentation and follow-through will be addressed with the assigned partners immediately. Evaluation of performance: • ADL Audit tool to be completed as described above monthly x 3 months with findings evaluated in the monthly Quality Assurance and Performance Improvement meetings. Corrective Actions to be completed by 10/1/25.	10/01/2025
S1210	Pharmaceutical Services - Labeling CFR(s): 10.07.02.26 D .26 Pharmaceutical Services. D. Labeling.	S1210		

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S1210	Continued from page 2 (1) Medications shall be accurately and plainly labeled. Except for those over-the-counter medications that the Department may list as suitable for purchasing in bulk and dispensing as needed, the labels for all medications shall bear at least: (a) The resident ' s full name; (b) The name of the drug; (c) Strength; (d) Original filling date and date refilled, if applicable; (e) Name of authorized prescriber; (f) Expiration date of medication (month, year); (g) Any special handling and storage instructions; (h) Name and address of dispensing pharmacy; (i) Prescription number; (j) Number of tablets or capsules; and (k) Accessory federal labels. (2) A nurse may not package, repackage, bottle, or label any medication, in whole or in part, or alter any labeled medication in any way. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Refer to CMS 2567 F - 761	S1210	S1210 Cross Reference 2567 F 761 FTAG 761 D Facility failed to ensure proper temperature storage of medications to preserve medication integrity and properly label multidose m educations with the complete date. Immediate action taken all items identified during the survey were immediately discarded and reordered. Although all residents have the potential to be impacted by this deficient practice, none were identified. Implement measures and systemic changes: • Director of Health Services reviewed policy, Medication Storage in the Healthcare Centers for in-service guidance with clinical leadership team. • On August 28, 2025, the Director of Health Services (DHS) in-serviced the Assistant Director of Health Services (ADHS), Unit managers (UM) (Registered Nurses RN x4 and Licensed Practical Nurses LPN x2), Director of MDS Coordinator RN, Evening shift supervisor RN, LPN Electronic Medical Records Trainer, Quality Assurance RN, Infection Preventionist RN, and 2 Clinical Competency Coordinator RN (CCC)) on medication storage, dating multidose medications/supplements, and discardin those that are not kept at proper temperature or th that are improperly labeled with a legible opened date. • Starting August 29, 2025, the ADHS/UM/CCC/RN will utilize the written in-services provided by the DHS to educate the RN, LPN, and Certified Medication Assistants (CMA)s that provide medication administration. This will be completed by September 26, 2025.	10/01/25
S1220	Pharmaceutical Services - Storage CFR(s): 10.07.02.26 E	S1220		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18004	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/25/2025
NAME OF PROVIDER OR SUPPLIER: Charlotte Hall Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 29449 CHARLOTTE HALL ROAD , CHARLOTTE HALL, Maryland, 20622	

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S1220	Continued from page 3 .26 Pharmaceutical Services. E. Storage. (1) The nursing home shall store medications in a locked medication storage area that: (a) Is well lighted; (b) Is located where personnel preparing drugs for administration will not be interrupted; (c) Is spacious enough to allow separate storage of external and internal medications; (d) Is kept in a clean, orderly and uncluttered manner; and (e) Contains a refrigerator to be used for medication storage only. (2) The nursing home shall keep poisons and medications marked "for external use only" separate from general medications and Schedule II drugs. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Refer to CMS 2567 F761	S1220	S1210 & S1220 Cross Reference to CMS 2567 F761 Cont'd Any licensed staff and medication aides on FMLA or PTO will receive the education upon their return to work. • Medication Storage will continue to be reviewed during the new hire orientation. Facility will monitor compliance with securing the unattended medication cart. • Starting September 2, 2025, the night shift charge nurses on each unit will complete the medication cart audit tool every Sunday and Wednesday to identify proper medication storage. • Any deficiency will be addressed immediately. Evaluation of performance: • Medication Cart Audit tool to be completed as described above x 3 months with findings evaluated in the monthly Quality Assurance and Performance Improvement meeting Corrective Actions to be completed by 10/1/25.	10/01/2025
S1450	Infection Prevention and Control Program CFR(s): 10.07.02.33 E .33 Infection Prevention and Control Program. E. Infection Prevention and Control Policies and Procedures. (1) The infection prevention and control program shall establish written policies and procedures to identify, investigate, control, and prevent infections in the	S1450		

Maryland State Department of Health

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S1450	Continued from page 4 nursing home, including policies and procedures to: (a) Identify health care-associated infections and communicable diseases in accordance with COMAR 10.06.01; (b) Report occurrences of certain infectious diseases and outbreaks of infectious diseases to the local health department in a timely manner in accordance with COMAR 10.06.01 and Health-General Article, §18-202, Annotated Code of Maryland; (c) Institute appropriate control measures when an infection or outbreak of infections is suspected or identified in order to control infection and prevent spread to other residents; (d) Perform surveillance for health care-associated and community-associated infections of residents and employees using definitions and methods approved by the infection prevention and control oversight committee to monitor and investigate causes of infection, and the manner in which the infection is spread; (e) Train employees about infection prevention and control, including: (i) Standard precautions and hand hygiene; (ii) Respiratory hygiene and cough etiquette; (iii) Soiled laundry and linen processing; (iv) Safe handling of needles and sharps and safe injection techniques; (v) Special medical waste handling and disposal; (vi) Appropriate use of antiseptics and disinfectants; (vii) Blood-borne pathogens, including hepatitis B and C and human immunodeficiency virus;	S1450	S1450 & S1460 Cross Reference CMS 2567 F880 Facility failed to ensure infection control procedures were maintained properly in four areas: multi-use equipment was not properly sanitized after each use, proper signage for transmission based precautions, urinary drainage bag port was on floor, and oxygen tubing was on floor. Immediate action taken: the Anti germicidal wipe was placed on the medication cart for glucometer meter cleaning, the EBP signage was removed while the contact isolation signage remained, the urinary drainage bag and oxygen tubing were replaced immediately once identified. Although all residents have the potential to be impacte by this deficient practice, none were identified. Implement measures and systemic changes: • Director of Health Services reviewed policies, Infectior Control: Glucometer Cleaning and Disinfecting and Transmission Based Isolation Precautions for in-service guidance with clinical leadership team. • On August 28, 2025, the Director of Health Services (DHS) in-serviced the Assistant Director of Health Servi (ADHS), Unit managers (UM) (Registered Nurses RN x4 and Licensed Practical Nurses LPN x2), Director of MDS Coordinator RN, Evening shift supervisor RN, LPN Electronic Medical Records Trainer, Quality Assurance RN, Infection Preventionist RN, and 2 Clinical Competency Coordinator RN (CCC) on infection control and prevention measures related to glucometer cleaning, proper isolation signag drainage bags placement, and oxygen tubing placemer • Starting August 29, 2025, the ADHS/UM/CCC/RN will utilize the written in-services provided by the DHS to educate the RN, LPN, and Certified Medication Assistants (CMA)s that provide direct patient care. This will be completed by September 26, 2025. • Infection control will continue to be reviewed during the new hire orientation. • Any clinical partner on FMLA or PTO will receive the education upon their return to work. The facility will monitor compliance with the identified infection control protocols utilizing the compliance rounds audit tool to capture drainage bag, proper isolation signage, and oxygen bag placement. The glucometer cleaning checklist will be utilized to ensure nurses are cleaning the meter properly.	10/01/2025

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S1450	Continued from page 5 (viii) Tuberculosis exposure; and (ix) Proper use and wearing of personal protective equipment, such as gloves, gowns, and eye protection; (f) Train and perform compliance monitoring of employee application of infection prevention and control activities, such as hand hygiene and personal protective equipment used for isolation precautions; (g) Review the infection prevention and control program elements at least annually and revise as necessary; and (h) Obtain annual approval of infection prevention and control program activities by the infection prevention and control oversight committee. (2) The nursing home shall provide information concerning the infectious disease status of any resident being transferred or discharged to any other nursing home, including a funeral home. (3) The nursing home shall obtain information concerning the infectious disease status of any resident being transferred or admitted to the nursing home from elsewhere. This LICENSURE REQUIREMENT is NOT MET as evidenced by: See CMS 2567 F880	S1450	S1450 & S1460 Cross Reference CMS F880 cont'd Starting September 2, 2025, the compliance rounds audit tool will be completed weekly on every nursing unit to audit all residents with foley bags, residents with oxygen tubing, and residents on isolation. Any non-compliance will be addressed immediately. To be done weekly x4, then monthly x2. • The Glucometer cleaning checklist will be completed on at least 7 nurses per week. Any non-compliance areas will be addressed/ corrected immediately, weekly x4, then monthly x2. • Any deficiency will be addressed immediately. Evaluation of performance: • The compliance audit tool and the glucometer cleaning checklist to be completed as above-described x 3 months with findings evaluated in the monthly Quality Assurance and Performance Improvement meetin Corrective Actions to be completed by 10/1/25. S2910 Cross Reference CMS F656 Facility failed to ensure resident #74 had a care plan implemented due to dental concerns. Immediate actions taken to resolve issue: Resident #74 had a dental care plan implemented on 7/23/25. All the residents with natural teeth have the potential to be impacted by this deficient pract Implement measures and systemic changes: • Director of Health Services reviewed policy, Care Plan, for in-service guidance with clinical team. • On August 28, 2025, the Director of Health Services (DHS) in-serviced the Assistant Director of Health Services (ADHS), managers (UM) (Registered Nurses RN x4 and Licensed Practical Nurses LPN x2), of MDS Coordinator RN, Evening shift supervisor RN, LPN Electronic Medical Records Trainer, Quality Assurance RN, Infection Preventionist RN, and 2 Clinical Competency Coordinator RN (CCC) on care plan updates for dental concerns. • MDS Coordinator Director to in-service other MDS coordinators regarding updating/initiating care plans when quarterly assessment reviews and significant changes assessments are being completed with dental care triggers. In-service to be completed by September 12, 2025.	10/01/202
S1460	Infection Prevention and Control Program CFR(s): 10.07.02.33 F .33 Infection Prevention and Control Program. F. Preventing Spread of Infection. (1) The facility shall assess any residents with signs and symptoms of an infectious illness for the possibility of transmission to another resident or employee.	S1460		

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S1460	Continued from page 6 (2) The nursing home shall take appropriate infection prevention and control measures to prevent the transmission of an infectious disease to residents, employees, and visitors as outlined in the following guidelines: (a) 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings; and (b) Guideline for Infection Control in Health Care Personnel. (3) The nursing home shall prohibit employees with an infectious disease or with infected skin lesions from having direct contact with residents or their food if direct contact could transmit the disease. (4) The nursing home shall require employees to perform hand hygiene before and after each direct resident contact for which hand hygiene is indicated by accepted professional practice. (5) The facility shall handle, store, process, and transport linens so as to prevent the spread of infection. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Refer to CMS 2567 F - 880	S1460	cont 'd S2910 Cross Reference CMS F656 Starting August 29, 2025, the ADHS/UM/CCC/RN will utilize the written in-services provided by the DHS to educate the RN & LPN. Th will be completed by September 26, 2025. • Any licensed nurse on FMLA and PTO will receive the education upon their return to work. • An initial audit of all residents that were seen by the dentist during the past 6 months will have their care plans reviewed to ensure a dental c plan was implemented. This will be completed by the DHS by September 19, 2025. Immediate correction will be completed by the DHS at the time of the audit. Facility will monitor compliance by completing the Dental care plan audit tool. • Starting September 20, 2025, with each dental appointment, the residents' care plans will be reviewed by the UM/ADHS/RN/DHS to ensure the care plan is in place and up to date. This audit will be noted on the dental care pl. audit tool. • If no care plan is noted, a dental care plan will be initiated immediately. Evaluation of performance: • Dental Care plan Audit tool to be completed as described above monthly x 3 months with findings evaluated in the monthly Quality Assurance and Performance Improvement meetings. Corrective Actions to be completed by 10/1/25.	10/01/2025
S2910	Care Planning-Timing CFR(s): 10.07.02.60 A .60 Care Planning. A. An interdisciplinary team shall complete or revise as necessary a resident-specific care plan for each resident within 7 calendar days following completion of assessments, including: (1) Admission assessment;	S2910		

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S2910	Continued from page 7 (2) Annual assessment; (3) Quarterly assessment; and (4) Significant change in the resident's condition. This LICENSURE REQUIREMENT is NOT MET as evidenced by: See CMS 2567 F656	S2910	S5093 Cross Reference CMS F558 Facility failed to ensure residents (80, #90, #125, #190, #201) had their call lights within reach. Immediate actions taken to resolve issue: the unit manager completed rounds on the unit to ensure proper placement of call lights when notified by the surveyor on 7/16/2025. All the residents at the facility have the potential to be impacted by this deficient practice. Implement measures and systemic changes: • Director of Health Services reviewed policy, Nursing: Patient/Residents Rights, Needs/Preference for in-service guidance and review with clinical leadership team. • On August 28, 2025, the Director of Health Services (DHS) in-serviced the Assistant Director of Health Services (ADHS), Unit managers (UM) (Registered Nurses RN x4 and Licensed Practical Nurses LPN x2), Director of MDS Coordinator RN, Evening shift supervisor RN, LPN Electronic Medical Records Trainer, Quality Assurance RN, Infection Preventionist RN, and 2 Clinical Competency Coordinator RN (CCC) on ensuring proper placement of the call lights for residents to request assistance as needed. Starting August 29, 2025,the ADHS/UM/CCC/RN will utilize the written in-services provided by the DHS to educate the clinical and non-clinical staff members. This will be completed by September 26, 2025. • Any staff member on FMLA or PTO will receive education upon their return to work. • Accommodation of needs with call light accessibility will continue to be reviewed during the new hire orientation. Facility will monitor compliance by completing the "Compliance Rounds Audit Tool". The Compliance Rounds Audit Tool identifies if the call light is within easy reach. Starting September 2, 2025 the UMs/ADHS/RN will do 5 random room audits per nursing unit each weekday shift supervisors will do 10 random room audits per day and document finding on the compliance rounds audit tool. • If the call light is not within easy reach, the auditor will immediately reposition the call light to be within easy reach. Auditors will notify charge nurse assigned of their findings. Evaluation of performance: - Compliance Rounds Audit tool to be completed as described above x 3 months with findings evaluated in the monthly Quality Assurance and Performance Improvement meetings. Corrective Actions to be completed by 10/01/2025.	10/01/202
S5093	Right to reasonable accommodation CFR(s): 10.07.09.08 C (1) .08 Resident's Rights and Services. C. A resident has the right to: (1) Reside and receive services in a nursing facility with reasonable accommodations of individual needs and preferences, except when accommodations would endanger the health or safety of the resident or other residents; This LICENSURE REQUIREMENT is NOT MET as evidenced by: See CMS 2567 F558	S5093		
S5097	Right to dignified existence CFR(s): 10.07.09.08 C (3) .08 Resident's Rights and Services. C. A resident has the right to: (3) A dignified existence, self-determination, and communication with and access to individuals and services inside and outside the nursing facility; This LICENSURE REQUIREMENT is NOT MET as evidenced by: See CMS 2567 F550	S5097	S5097 Cross Reference CMS F550 The facility staff failed to ensure a dignified existence was maintained due to R #123 fitted sheet was heavily soiled, and the mattress was half covered. The heavily soiled linen was discarded when resident #123 allowed staff to change linen. Although all of Charlotte Hall Veterans Servic residents who refuse hygienic care and linen changes have the potential to be impacted by this deficient practice, no other residents have been identified as being impacted. Implement measures and systemic changes: • On August 28, 2025, the Director of Health Services (DHS) in-serviced the Assistant Director of Health Services (ADHS), Unit managers (UM) (Registered Nurses RN x4 and Licensed Practical Nurses LPN x2), Director of MDS Coordinator RN, Evening shift supervisor RN, LPN Electronic Medical Records Trainer, Quality Assurance RN, Infection Preventionist RN, and 2 Clinical Competency Coordinator RN (CCC) on addressing resident's refusal of care to include: the geriatric nursing assistants (GNA) should notify the nurse of all refusals of care (including changing soiled linen), ther the nurse and GNA should ask/offer (at different times) the resident to allow therr to provide care/linen changes.	
S6000	Right to freedom from abuse CFR(s): 10.07.09.08 C (5) .08 Resident's Rights and Services.	S6000		

Maryland State Department of Health

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S6000	Continued from page 8 C. A resident has the right to: (5) Be free from: (a) Physical abuse; (b) Verbal abuse; (c) Sexual abuse; (d) Physical or chemical restraints imposed for purposes of discipline or convenience; (e) Mental abuse; and (f) Involuntary seclusion; This LICENSURE REQUIREMENT is NOT MET as evidenced by: See CMS 2567 F605	S6000	S5097 Cross Reference CMS F550 cont'd • Starting August 29, 2025, the ADHS/UM/CCC/RN will utilize the written in-services provided by the DHS to educate the clinical team: RN, LPN, and GNAs. This will be completed by October 1, 2025. • Residents' rights will continue to be reviewed during the new hire orientation. • Facility will monitor compliance by completing the "Compliance Rounds Audit Tool". The Compliance Rounds Audit Tool identifies if linen is clean and mattress is covered. • Starting September 1, 2025, the UMs/ADHS/RN will do 5 random room audits per nursing unit each weekday and the weekend shift supervisors will do 10 random room audits per day and document finding on the compliance rounds audit tool. • If linen is soiled or bed not properly made during the room audits, the auditor will notify the assigned charge nurse and G.N.A for correction. • Evaluation of performance: • Compliance Rounds Audit tool to be completed as described above x 3 months with findings evaluated in the monthly Quality Assurance and Performance and Improvement meetings.	10/01/2025
S6655	Food Protection During Storage, Service and T CFR(s): 10.15.03.06 B (7) .06 Food Protection. B. When Storing and Holding. (7) Except as provided in §B(8)-(14) of this regulation, the internal temperature of a potentially hazardous food is kept at 41F or less or 135F or greater; This LICENSURE REQUIREMENT is NOT MET as evidenced by: Refer to CMS 2567 F812	S6655	S6655 Cross Reference to CMS F812 A) The CDM took the Refrigerator #4's temp & documented it at 5:15am temperature on 7/15/25 read as 39 degrees Fahrenheit, when taken during the walk through on temperature #4, it read over 41 degrees Fahrenheit from the hanging thermometer, therefore the CDM placed the #4 refrigerator out of order as reflected on the temperature log sheet. The CDM (Certified Dietary Manager) also corrected and removed eyeglasses placed on top of dishwasher immediately along with removing the 38-ounce personal drinking container on top of dishwasher. The CDM immediately placed an Out of Order Sign on the hand wash sink in the dish washer area and corrected and filled the empty towel dispenser along with soap dispenser same day of walk through. The CDM also filled the paper towel dispenser located next to the hand sink near the walk-in fridge of the prep area of the kitchen the same day of walk through. The CDM immediately referred to the pull date log and labeled the raw chicken on the long silver tray in reference to the three blue bags of raw chicken thawing for date to be used. In addition, CDM discarded the egg salad temped after being made same day stating the egg salad was rechecked via temperature, however was unable to continue through the cooling process (under two hours before the temperature was taken again). CDM also discarded the deli meat sandwiches immediately after walking through. No residents were affected and all kitchen staff in-serviced began on 8/28/2025 by the CDM and Administrator. B) The CDM (Certified Dietary Manager) and Administrator completed a walk through on 7/17/2025 through the kitchen to ensure the kitchen food service equipment is in good working manner and to ensure safe and sanitary food service operations are maintained, labeled properly and served in accordance with professional standards for food service safety. No residents were affected. All corrected actions to be completed by 10/1/2025. C) The root cause analysis determined that staff and CDM failed to follow policy and procedure for food safety and sanitation, as evidence and failed to maintain food service equipment in a manner that ensures safe and sanitary food service operations. All kitchen and/or dietary staff received education that began on 8/28/25, including the CDM by the Administrator. D) The CDM and/or assistant to CDM along with the administrator will continue to conduct audits to ensure the kitchen food service equipment is in good working manner and to ensure safe and sanitary food service operations are maintained, labeled properly and served in accordance with professional standards for food service safety. The audits will be completed daily, or once 100% compliance is achieved for five consecutive days. The audits will continue to occur 5x a week for 3 consecutive weeks, or until 100% compliance is achieved for 3 consecutive months. Audit findings will be reported to the QAPI committee and will monitor monthly log reports.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **215161**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/13/2025**

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F0000	INITIAL COMMENTS On June 12 and 13, 2025, a on-site revisit survey was conducted by the Office of Health Care Quality to determine the status of the facility's compliance with the plan of correction submitted for deficiencies cited during the survey that concluded on April 4, 2025. The licensed bed capacity for this facility was 284 and the resident census at the start of the survey was 212 residents. Survey activities consisted of a tour of the facility, a review of medical records and facility documentation, interviews with facility staff as well as observations of resident and staff practices. Effective May 16, 2025, the facility was determined to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. This survey did not identify non-compliance with Federal and state regulations.	F0000		

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 reverse for further 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

Maryland State Department of Health

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S0000	Initial Comments No Information	S0000		

Office of Primary Care and Health Systems Management

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