Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Charlotte Hall Veterans Home

Location: 29449 Charlotte Hall Rd. Charlotte Hall, Maryland 20622

Onsite / Virtual: Onsite

Dates of Survey: 8/15/22-8/18/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 286

Census on First Day of Survey: 207

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from August 15, 2022, through August 18, 2022, at the Charlotte Hall Veterans Home. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.100 (a) Dignity. The facility management must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected - Some	Based on observation and interview, the facility failed to promote dignity in dining by serving meals in the common area on the trays and using plastic cups. The facility also failed to promote dignity in the residents' bathrooms by using plastic or fabric curtains instead of doors for the entrances into the connecting bathrooms of 12 out of 27 rooms on the secured neighborhood, which affected 37 out of 37 residents on [LOCATION] neighborhood. The findings include: 1.During a meal observation on the [LOCATION], on 8/15/22, at 12:30 p.m., Certified Nurse Aide A took a thin, plastic disposable cup to fill with a drink, then placed it on the tray. They then placed the entire tray and disposable plastic cup in front of Resident #11. During the meal observation, all portions of the meals were served to the residents on trays with thin, plastic disposable cups. Dessert was served to all 37 residents on paper plates.

	During a group interview, on 8/16/22, at 9:40 a.m. with Licensed Nurse A, Certified Nurse Aide B, Certified Nurse Aide C, Certified Nurse Aide D, and Licensed Nurse B, they all said that they had been serving the residents disposable plastic cups on the meal trays for as long as they had been there. Licensed Nurse B said that they had worked there for five (5) years, and they were serving plastic disposable cups on the meal trays on [LOCATION] when they first started working at the facility. They said that there were no hard plastic cups sent to their [LOCATION] for the residents to drink out of. On 8/18/22, at 11:10 a.m., during an interview with Administrative Staff A and Administrative Nurse A, about the use of disposable plastic cups and food being served on the meal tray for residents living on [LOCATION], they said that they had been using the plastic disposable cups. They further stated that they were not sure how long that it had been happening, and they were aware the residents received meals served on trays. During the exit conference, on 8/18/22, at 1:06 p.m., Administrative Staff B said that on the [LOCATION], all meals should be taken off the trays and no disposable cups should be used: “The residents should be treated with dignity.” 2. During a brief tour of [LOCATION on 8/15/22, at 11:50 a.m., it was revealed that plastic shower curtains were used instead of doors between the residents’ rooms and their bathrooms inside the room (not community shower rooms). During an interview with Licensed Nurse A, the Unit Manager for [LOCATION], on 8/15/22, at 11:56 a.m., they stated that there were 37 residents who resided on this [LOCATION] and that the shower curtains had been there for the 5 years that they had been there. During a group interview on 8/16/22, at 9:47 a.m., with Licensed Nurse A, Licensed Nurse B, Certified Nurse Aide B, Certified Nurse Aide C, and Certified Nurse Aide D, Licensed Nurse A said that Administrative Nurse B knew that the [LOCATION] was using plastic shower curtains instead of regular doors as a visual privacy barrier into the shared bathrooms. They stated that it had been that way since the building opened (more than 18 years ago). Licensed Nurse B said that the bathroom privacy doors previously slid open and closed, but about five (5) years ago there were issues with the wooden sliding doors breaking, and those were replaced with curtains. During an interview on the [LOCATION], on 8/16/22, at 10:16 a.m., Resident #11 pointed out that the fabric curtain into the bathroom for room [LOCATION] was not wide enough to cover

	the doorway and that they had no privacy no matter what they tried. During an observation, on 8/16/22, at 11:11 a.m., [LOCATION] had a plastic shower curtain instead of a door at the entrance to the bathroom between [LOCATION] and [LOCATION], and a plastic shower curtain instead of a door inside the bedroom between [LOCATION] and [LOCATION]. Upon further investigation, there were no privacy doors in the bedrooms leading into the bathrooms. There were only shower curtains or fabric curtains on the [LOCATION] in [LOCATION], [LOCATION], [LOCATION], [LOCATION], [LOCATION], [LOCATION], [LOCATION], [LOCATION], [LOCATION], [LOCATION], [LOCATION], and [LOCATION]. There were no privacy doors going into the bathrooms in 12 of 27 rooms. During an observation, on 8/16/22, at 11:30 a.m., Resident #15, in [LOCATION], had a semi-private room and only a plastic shower curtain, instead of a door, between the room and the shared bathroom. During an interview with Administrative Nurse B, on 8/17/22, at 1:22 p.m., they stated that they were aware that the [LOCATION] used shower curtains instead of doors into the bathrooms that connected the rooms. Administrative Nurse B said that the curtains were used on [LOCATION] only because a resident injured themselves and blocked other residents while locking themselves in the bathroom. They stated this event occurred more than 18 years ago and the practice had not been reevaluated since then. Administrative Nurse B stated that the [LOCATION] was the only unit that used shower curtains instead of doors leading into the bathrooms. During an observation in Resident #13's Room, [LOCATION], on 8/18/22, at 10:29 a.m., while looking toward the shared bathroom, the surveyor could clearly see activities of daily living (ADLs) being provided by the staff to Resident #12. The shower curtain for the shared bathroom was not pulled closed in Room [LOCATION] by the Certified Nurse Aide before providing care. During an interview with Resident #14 in [LOCATION], on 8/18/22, at 10:32 a.m., they said, "I'd have better privacy with a door." During an interview with Resident #19 in [LOCATION], on 8/18/22, at 10:36 a.m., they said, "I wish I had a door instead of a curtain to close to the bathroom." During an interview with Administrative Staff A and Administrative Nurse A, on 8/18/22, at 11:14 a.m., they were not aware that there were only curtains leading into the residents'

	room bathrooms, including the private and semi-private shared bathrooms. The semi-private room had four (4) residents who could use the same bathroom on their own. Administrative Staff A and Administrative Nurse A stated that they were not aware of this situation until it was brought to their attention by the surveyors' questions. Administrative Staff A and Administrative Nurse A said all residents deserve to be treated with dignity.
§ 51.120 (b) (3) Activities of daily living. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, hydration, grooming, personal and oral hygiene, mobility, and bladder and bowel elimination. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	Based on observation, interview, and record review the facility failed to provide the necessary services to maintain good grooming related to nail care for one (1) resident (Resident #17) and removal of facial hair for one (1) resident (Resident #19). There were 35 sampled residents. The findings include: The facility policy for the provision of Activities of Daily Living/Grooming (ADL) was requested on 8/17/22, and was not received prior to exiting the facility survey on 8/18/22. Correspondence from Administrative Staff A by email on 8/22/22, at 3:21 p.m., revealed that the facility had no ADL policy. 1. An interview with Resident #17, on 8/15/22, at 2:00 p.m., revealed that they needed to see the Podiatrist. The resident stated that they had not seen the Podiatrist in six (6) months. Resident #17 stated, "look at my toes." During an observation of Resident #17's toes with Administrative Nurse C, immediately after Resident #17's request, it was revealed that their toenails were long and large and ingrown. A reddish-brown substance that looked like dried blood was observed at the junction of the nails to the nail beds of the right great toe and right second toe. Resident #17 stated that their feet were very uncomfortable. Administrative Nurse C stated that the resident was in the hospital when the Podiatrist had made rounds the last time. They also stated that Resident #17 refused to go to the VA downtown because of discomfort during travel and the amount of travel time. Resident #17 could not visit the local Podiatrist because they required a stretcher and could not be transported in a wheelchair. Administrative Nurse C stated that they would get Licensed Nurse C to assess Resident #17's toes and find a Podiatrist. Review of the Annual Minimum Data Set (MDS) for Resident #17, dated [DATE], revealed the resident had a Brief Interview Mental Status (BIMS) score of 15, which indicated that he/she was cognitively intact. Resident #17 required extensive assistance of one (1) person for personal hygiene.

	Review of the Care Plan for Resident #17 revealed a problem, dated [DATE], and last revised [DATE], for risk for impaired skin integrity secondary to Cerebrovascular Accident (CVA) with Right Hemiparesis, Seizures, Psychotropic Medication Use, Diabetes Mellitus, Contracture Right Hand, History of Pressure Injury, and History of Deep Vein Thrombosis, and Right-Hand Splint. The Goal and Target Date for the Care Plan was [DATE] and indicated that the resident would remain free from development of skin breakdown due to pressure, impaired circulation or diabetes during the next review period. Approaches included: [DATE], Routine podiatry care as ordered-observe for signs/symptoms of diabetic changes to skin and notify MD prn (as needed). Record review of a "Report of Consultation," dated [DATE], for Resident #17 by the Podiatrist revealed that Resident #17 was treated for hypertrophic nails 10 times. Diagnoses were onychocryptosis (ingrown toenails) and onychomycosis. Recommended wedge resection of incarcerated nail. Debridement of nails x 2 (times two). An interview with Administrative Nurse C, on 8/17/22, at 10:00 a.m., revealed that Resident #17 went out to the hospital last evening for an unrelated condition, but had been scheduled to see the facility Podiatrist on that Friday, [DATE]. 2. During an interview and observation of Resident #19, on 8/16/22, at 10:30 a.m., they stated that it had been a while since they had had their face shaved. The surveyor observed about a quarter inch growth of facial hair (beard). When asked why they had not been shaved, the resident responded that they had not been offered a shave. Review of the Quarterly MDS for Resident #19, dated [DATE], revealed a BIMS score of seven (7), which indicated severe cognitive impairment. Resident #19 had no behaviors of refusing or resisting care indicated on the assessment. The resident was totally dependent on one (1) person for hygiene and bathing. Review of the Care Plan, which was updated [DATE], for Resident #19 revealed: Required staff assistance for basic daily care needs due to generalized weakness related to recent hospitalization. Interventions included to remove facial hair PRN.

	A written statement was received from Administrative Nurse D and Licensed Nurse D, on 8/18/22, at 12 p.m., dated 8/17/22, (untimed), that the Certified Nurse Aide had offered to shave Resident #19 when he/she was in the shower on [DATE], which he/she declined "at that moment." However, there was no documentation that he/she was offered a shave prior to the [DATE], interview. The facility failed to provide nail care/treatment as needed to Resident #17, which contributed to discomfort due to preexisting ingrown toenails. The facility also failed to ensure Resident #19 was shaved as they desired.
§ 51.200 (a) Life safety from fire. The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. (a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Some	**Means of Egress** 1. Based on observations and interview, the facility failed to prohibit locks on doors in the means of egress that could not be unlocked from the egress side. The deficient practice affected one (1) of three 22 smoke compartments, staff, and 32 residents. The facility had the capacity for 286 beds with a census of 207 on the day of survey. The findings include: Observation during the building inspection tour, on 8/16/22, at 11:17 a.m., revealed the exit door on [LOCATION] was equipped with a dead bolt lock that could not be unlocked from the egress side, as prohibited by 19.2.2.2.4 of NFPA 101, Life Safety Code. Further observation revealed that there was no way to unlock the door from the egress side. An interview at that time with Maintenance Staff A revealed the facility was not aware that type of lock was not permitted. The census of 207 was verified by Administrative Staff A on 8/15/22. The findings were acknowledged by Administrative Staff A, Maintenance Staff A, and verified by Maintenance Staff B during the exit interview on 8/18/22, at 1:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side, unless otherwise permitted by one of the following: (1) Locks complying with 19.2.2.2.5 shall be permitted. (2)*Delayed-egress locks complying with 7.2.1.6.1 shall be permitted. (3)*Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. (4) Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted.

	(5) Approved existing door-locking installations shall be permitted. 7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. 7.2.1.5.2* The requirement of 7.2.1.5.1 shall not apply to door leaves of listed fire door assemblies after exposure to elevated temperature in accordance with the listing, based on laboratory fire test procedures. 7.2.1.5.3 Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. 7.2.1.5.4 The requirements of 7.2.1.5.1 and 7.2.1.5.3 shall not apply where otherwise provided in Chapters 18 through 23. 2.Based on observations and interview, the facility failed to ensure exit pathways were free of obstructions. The deficient practice affected one (1) of 22 smoke compartments, staff, and 32 residents. The facility had the capacity for 286 beds with a census of 207 on the day of survey. The findings include: Observation during the building inspection tour on 8/16/22, at 11:24 a.m., of the [LOCATION], revealed the exit gate which led to the public way from the courtyard was binding on the ground and could not be opened, as prohibited by section 7.1.10.1 of NFPA 101, Life Safety Code. An interview at that time with Maintenance Staff A revealed the facility was unaware that the exit gate was binding on the ground and could not be opened. The census of 207 was verified by Administrative Staff A on 8/15/22. The findings were acknowledged by Administrative Staff A, Maintenance Staff A, and verified by Maintenance Staff B during the exit interview on 8/18/22, at 1:00 p.m. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012)** 19.2 Means of Egress Requirements. 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. 7.1.10 Means of Egress Reliability. 7.1.10.1* General. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.1.10.2 Furnishings and Decorations in Means of Egress. 7.1.10.2.1 No furnishings, decorations, or other objects shall

	obstruct exits or their access thereto, egress therefrom, or visibility thereof.