| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 215161 | A. Building<br>B. Wing | 04/04/2025 |

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| Charlotte Hall Veterans Home | 29449 Charlotte Hall Road<br>Charlotte Hall, MD 20622 |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52124<br><br>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.<br><br>The Findings Include:<br><br>Review of R17's Face Sheet documented R17 was admitted on [DATE]. The face sheet showed G32 was a medical court appointed guardian.<br><br>Review of R17's care plan dated [DATE] directed staff to notify G32 of any changes to R17's health status.<br><br>Record Review of the annual Minimum Data Set assessment (MDS), dated [DATE], revealed R17 had a BIMS score of ,d+[DATE] (indicating severe mental impairment). R17 was dependent on staff regarding activities of daily living (ADLs).<br><br>Record review of R17's SBAR form dated [DATE] 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.<br><br>Record review on R17's progress notes dated [DATE] 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.<br><br>Record Review of R17's Progress Note staff documented on [DATE] 08:59 PM, R17 was noted with no respiration nor pulse. R17 was pronounced deceased at 7:00 PM.<br><br>During an interview on [DATE] 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 attempts until they reach them. LPN15 concluded she was unable to see where staff documented they contacted R17s guardian, G32.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on [DATE] at 10:30 AM, G32 revealed she was R17's state appointed medical guardian. G32 stated on [DATE] she was disappointed when facility staff sent R17 to the hospital without notifying her.<br><br>During an interview on [DATE] at 12:15 PM, the Director of Nursing (DON) stated, R17 had a court appointed guardian and explained on [DATE], R17 was sent to the ER. DON stated staff should have made sure G32 was notified when staff sent R17 to hospital.<br><br>During an interview on [DATE] 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.<br><br>During an interview on [DATE] 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.<br><br>During an interview on [DATE] at 12:38 PM, the Administrator said nurses or the social worker should contact the family when there was a change in condition. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>41274<br><br>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.<br><br>Cross reference to F684: Quality of care<br><br>The findings include:<br><br>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 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.<br><br>Review of facility's Code Purple timeline and documentation revealed the following:<br><br>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.<br><br>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.<br><br>Upon request, the facility could not provide temperature monitoring logs from 4/30/24 and prior to 4:30 PM on 5/1/24.<br><br>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.<br><br>On 5/1/24 at 9:18 AM, the facility notified the County EMA of the Code Purple.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 5/1/24 facility staff went out to purchase fans to provide to the residents.<br><br>On 5/1/24 at 10:47 AM, the facility was contacted by the County EMA, who offered assistance and additional resources.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>On 5/2/24 at 11:30 AM, the power was restored to the cooling towers.<br><br>On 5/2/24 at 12:01 PM, the Code Purple was cleared by the Nursing Home Administrator (NHA).<br><br>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.<br><br>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 management.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>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.<br><br>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 for the weather to be as hot as it was during that time of year.<br><br>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.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/3/25 at 12:01 PM, the 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. |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>41274<br><br>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 5/2/24, 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.<br><br>Cross reference to F584: safe, clean, comfortable, homelike environment<br><br>The findings include:<br><br>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 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.<br><br>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.<br><br>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 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.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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.<br><br>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 4/14/24 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.<br><br>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. 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.<br><br>A Dietary Order dated 1/10/24 ordered the resident to receive honey thick liquids.<br><br>A Physician Order dated 3/12/24 ordered staff to encourage thickened water intake during every shift.<br><br>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.<br><br>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.<br><br>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.<br><br>A Nursing Progress Note dated 5/2/24 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 the emergency room at 10:30 AM via emergency medical services (EMS).<br><br>A Hospital Discharge Summary dated 5/2/24 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.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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 5/2/24 and was sent out to the hospital. They reviewed Resident #9's hospital discharge summary and stated the labs obtained were significant for dehydration.<br><br>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.<br><br>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 5/2/24 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.<br><br>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 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.<br><br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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 5/2/24 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.<br><br>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. |