

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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, MD 20622	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on 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. 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.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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 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.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 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 him to meet his needs on his 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.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. 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. 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 dose 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 he 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.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 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 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.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 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 him they don't have a wheelchair to take him to get a shower. On 07/23/25 at 11:25 AM during an interview with 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.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and staff interview it was determined that the facility staff failed to: 1.) 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.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 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 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. 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 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.		