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, MD 20622

Onsite / Virtual: Onsite

Dates of Survey: 7/26/24

NH / DOM / ADHC: DOM

Survey Class: Annual

Total Available Beds: 168

Census on First Day of Survey: 54

VA Regulation Deficiency	Findings
	Initial Comments: A VA annual survey was conducted on July 26, 2024, 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.
§51.43 (b) Drugs and medicines for certain veterans VA will also furnish drugs and medicines to a State home for a veteran receiving nursing home, domiciliary, or adult day health care in a State home pursuant to 38 U.S.C. 1712(d), as implemented by § 17.96 of this chapter, subject to the limitation in § 51.41(c)(2). **Level of Harm** – No Actual Harm, with potential for minimal harm **Residents Affected** – Few	The facility was unable to demonstrate that drugs and medicines for individuals receiving care at the State home are furnished subject to the limitation in §51.41(c)(2). The findings include: Based on interviews and record reviews, it was identified that the facility has a process wherein a contracted, non-VA pharmacy is to provide drugs and medicines to all residents. During an interview on 7/26/24 at 10:00 a.m., Administrative Staff B identified that there are several Veteran residents who receive medications directly from the VA Medical Center (VAMC) of jurisdiction's pharmacy. During follow up communication, the facility identified that there are currently two (2) Veteran residents receiving drugs and medicines directly from the VAMC of jurisdiction's pharmacy. Upon review, it was confirmed that one (1) of the Veteran residents is in receipt of a VA Pension with Aid and Attendance; the other Veteran resident had no eligibility for VA-furnished drugs and medicines.

	Administrative Staff B relayed that the VAMC of jurisdiction had not been reimbursed for the drug and medicine costs for the one (1) Veteran resident identified as being ineligible. Administrative Staff B confirmed understanding that VA should only furnish drugs and medicines to Veterans who are eligible to receive such drugs and medicines.
§ 51.210 (j) Credentialing and Privileging. Credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care practitioner, which may include physicians, podiatrists, dentists, psychologists, physician assistants, nurse practitioners, licensed nurses to provide patient care services in or for a health care organization. Privileging is the process whereby a specific scope and content of patient care services are authorized for a health care practitioner by the facility management, based on evaluation of the individual's credentials and performance. (1) The facility management must uniformly apply credentialing criteria to licensed practitioners applying to provide resident care or treatment under the facility's care. (2) The facility management must verify and uniformly apply the following core criteria: current licensure; current certification, if applicable, relevant education, training, and experience; current competence; and a statement that the individual is able to perform the services he or she is applying to provide. (3) The facility management must decide whether to authorize the independent practitioner to provide resident care or treatment, and each credentials file must indicate that these criteria are uniformly and individually applied. (4) The facility management must maintain documentation of current credentials for each licensed	Based on interview and record reviews, the facility failed to maintain current and complete credentialing and privileging records for 12 of 12 Licensed Independent Practitioners (LIPs) who provided care to the residents. The findings include: Review of the facility's policy "Physician Credentialing and Privileging," last revised 10/13/23, revealed: "Purpose: To establish guidelines for the credentialing of physicians, mid-level providers & other allied healthcare professionals…Procedure for Pruitt Health Skilled Nursing Facilities and Veterans Facilities: …9. [Administrative Staff A] provides the licensed independent practitioner with a written list of any limitations on the care, treatment, and services the practitioner can provide. The licensed independent practitioner provides only the care, treatment, and services that they have been permitted to perform." During an interview and record review, on 7/26/24, at 11:28 a.m., of the Credentialing and Privileging files with Administrative Staff C, it was revealed 12 LIPs had incomplete Privileging files. Administrative Staff C revealed the Physician Privilege Request Section of the facility's Application for Appointment to the Medical Staff of Pruitt Health form, last reviewed 1/10/24, should have been completed by Administrative Staff A. During an interview with Administrative Staff B, on 7/26/24, at 1:50 p.m., Administrative Staff B revealed they were unaware Administrative Staff A hadn't completed the privileging and scope of practice for the 12 providers identified during the review. Administrative Staff B further stated they expected that Administrative Staff A documented each provider's privileges during the initial and reappointment phase.

independent practitioner practicing within the facility. (5) When reappointing a licensed independent practitioner, the facility management must review the individual's record of experience. (6) The facility management systematically must assess whether individuals with clinical privileges act within the scope of privileges granted. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	
§ 51.210 (p) (2) Quality assessment and assurance. The quality assessment and assurance committee— (i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develops and implements appropriate plans of action to correct identified quality deficiencies; and **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Based on interviews, record review, and review of the facility policy, the facility management failed to develop and implement appropriate Plans of Action related to Credentialing and Privileging. The facility's Corrective Action Plan (CAP) report submitted to the Veterans Affairs (VA) Geriatric and Extended Care (GEC) office from last year's 2023 annual survey documented several Plans of Action that had not been implemented into the facility's Quality Assurance and Performance Improvement (QAPI) Program. The findings include: Review of the facility's policy titled, "Quality Assurance and Performance Improvement Plan (SNF)," last reviewed 1/15/24, revealed: "Quality Assurance and Performance Improvement is the merger of two [2] complementary approaches to quality, Quality Assurance (QA) and Performance Improvement (PI). Both involve seeking and using information, but they differ in key ways: QA is the process of meeting quality standards and assuring that care and services reach an acceptable level. The process includes the systematic monitoring and evaluation of the various aspects of a project, service, or center/office/agency operations to ensure that standards of quality are being met. Skilled nursing rehabilitation centers (SNRC's), set quality assurance thresholds to comply with internally developed standards of performance and; also, to comply with all applicable state and Federal regulations…PI [Performance Improvement] (also called quality improvement—QI) is a pro-active and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems" [sic].

	Review of the facility's monthly QAPI minutes from September 2023, through December 2023, revealed the facility audited and reviewed Credentialing and Privileging files according to their CAP report submitted to the VA GEC. During an interview with Administrative Staff B, on 7/26/24, at 2:54 p.m., Administrative Staff B confirmed the facility did not audit the files to address both Credentialing and Privileging. Administrative Staff B stated the facility's audits that were addressed in the QAPI program consisted of the Credentialing process, and they were unaware Administrative Staff A did not address the privileges and scope of practice for 12 out of 12 Licensed Independent Practitioners (LIPs) reviewed. Administrative Staff B further revealed this should have been identified and addressed during QAPI with the QAPI committee. Administrative Staff A was not available for interview during the survey.
§ 51.210 (p) (3) Quality assessment and assurance. Identified quality deficiencies are corrected within an established time period. (4) The VA Under Secretary for Health may not require disclosure of the records of such committee unless such disclosure is related to the compliance with requirements of this section. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Based on interviews, record review, and review of the facility policy, the facility management failed to correct Plans of Action related to Credentialing and Privileging. The facility's Corrective Action Plan (CAP) report submitted to the Veterans Affairs (VA) Geriatric and Extended Care (GEC) office documented the facility would audit Credentialing files weekly for four (4) weeks then monthly for two (2) months and results of these audits would be forwarded to the QAPI (Quality Assurance and Performance Improvement) Committee for review and action as appropriate. The findings include: Review of the facility's policy titled, "Quality Assurance and Performance Improvement Plan (SNF)," last reviewed 1/15/24, revealed: "Quality Assurance and Performance Improvement is the merger of two [2] complementary approaches to quality, Quality Assurance (QA) and Performance Improvement (PI). Both involve seeking and using information, but they differ in key ways: QA is the process of meeting quality standards and assuring that care and services reach an acceptable level. The process includes the systematic monitoring and evaluation of the various aspects of a project, service, or center/office/agency operations to ensure that standards of quality are being met. Skilled nursing rehabilitation centers (SNRC's), set quality assurance thresholds to comply with internally developed standards of performance and; also, to comply with all applicable state and Federal regulations…PI [Performance Improvement] (also called quality improvement—QI) is a pro-active and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying

	areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems" [sic]. Review of the facility's QAPI minutes from September 2023, through December 2023, revealed the facility audited Credentialing and Privileging files. The QAPI minutes from December 2023 further indicated Credentialing and Privileging files had been accurate and completed per the facility's 2023 CAP report that was submitted to the VA GEC. During an interview with Administrative Staff B, on 7/26/24, at 2:54 p.m., Administrative Staff B revealed the facility was aware the Credentialing and Privileging files were an identified issue from last year's annual VA survey. Administrative Staff B stated the QAPI committee focused on Credentialing; however, they were unaware Administrative Staff A had not addressed the privileges and scope of practice for 12 out of 12 Licensed Independent Practitioners (LIPs) reviewed. Administrative Staff B confirmed that it was the QAPI committee's responsibility to address all identified concerns to ensure the identified concerns were addressed within an established time period. Administrative Staff A was not available for interview during the survey.
§ 51.350 (c) Life safety from fire. The facility must meet the applicable requirements of the National Fire Protection Association's NFPA 101, Life Safety Code, as incorporated by reference in § 51.200. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	**<u>Smoke Barriers and Sprinklers</u>** 1. Based on records review and interview, the facility failed to test and inspect the Fire Alarm in accordance with the code. The deficient practice affected 13 of 13 smoke compartments, staff, and all residents. The facility had the capacity for 168 beds with a census of 54 on the first day of the survey. The findings include: Record review, on 7/26/24, at 11:35 a.m., of the fire alarm testing and inspection records for the 12-month period prior to the survey revealed there was no documentation of semi-annual visual inspections of the smoke detectors as required by table 14.3.1 of NFPA 72, National Fire Alarm and Signaling Code. An interview, on 7/26/24, at 11:35 a.m., with Maintenance Staff A revealed the facility was unaware of the requirement to keep documentation of semi-annual visual inspections of the facility smoke detectors. Further interview revealed the facility only had visual inspections of the smoke detectors completed during the annual fire alarm system testing, which was last completed on 1/8/24.

	The census of 54 was verified by Administrative Staff B on 7/26/24, at 11:30 a.m. The findings were acknowledged by Administrative Staff B and verified by Maintenance Staff A during the LSC exit interview on 7/26/24, at 2:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **33.3.3.4.1 General**. A fire alarm system in accordance with Section 9.6 shall be provided, unless all the following conditions are met: (1) The facility has an evacuation capability of prompt or slow. (2) Each sleeping room has exterior exit access in accordance with 7.5.3. (3) The building does not exceed three stories in height. **9.6 Fire Detection, Alarm, and Communications Systems.** **9.6.1* General.** **9.6.1.1** The provisions of Section 9.6 shall apply only where specifically required by another section of this Code. **9.6.1.2** Fire detection, alarm, and communications systems installed to make use of an alternative permitted by this Code shall be considered required systems and shall meet the provisions of this Code applicable to required systems. **9.6.1.3** A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. **9.6.1.4** All systems and components shall be approved for the purpose for which they are installed. **9.6.1.5*** To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. **4.6.12 Maintenance, Inspection, and Testing.** **4.6.12.1** Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or other feature shall thereafter be continuously maintained. Maintenance shall be provided in accordance with applicable NFPA requirements or requirements developed as part of a performance-based design, or as directed by the authority having jurisdiction. **4.6.12.2** No existing life safety feature shall be removed or reduced where such feature is a requirement for new construction. **4.6.12.3*** Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed.

	4.6.12.4 Any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction. **10.2 Purpose.** The purpose of fire alarm and signaling systems shall be primarily to provide notification of alarm, supervisory, and trouble conditions; to alert the occupants; to summon aid; and to control emergency control functions. **10.3 Equipment.** **10.3.1** Equipment constructed and installed in conformity with this Code shall be listed for the purpose for which it is used. **Actual NFPA Standard: NFPA 72, National Fire Alarm and Signaling Code (2010)** **14.3 Inspection.** **14.3.1*** Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. **Table 14.3.1 Visual Inspection Frequencies** **Building Services** 2. Based on record review, interview, and observation, the facility failed to properly maintain the elevators as required by the code. The deficient practice affected zero (0) of zero (0) smoke compartments, staff, and no residents. The facility had a capacity for 168 beds with a census of 54 on the first day of the survey. The findings include: Document review, on 7/26/24, at 11:50 a.m., of the facility elevator testing and maintenance records revealed there was no recorded monthly test of the firefighter's emergency recall operation, as required by section 9.4.6.2 of NFPA 101, Life Safety Code. An interview, on 7/26/24, at 11:50 a.m., with Maintenance Staff B revealed the facility had not performed a monthly test of the Firefighters emergency recall, and was unaware of the requirement to test the Firefighters emergency recall feature. Additional interview revealed the facility was unaware if they were allowed to operate the Firefighter recall feature. Observation during the facility tour, on 7/26/24, at 12:00 p.m., revealed all staff and resident elevators were equipped with a Firefighters emergency recall feature.

The census of 54 was verified by Administrative Staff B on 7/26/24, at 11:30 a.m. The findings were acknowledged by Administrative Staff B and verified by Maintenance Staff A during the LSC exit interview on 7/26/24, at 2:00 p.m.

Actual NFPA Standard: NFPA 101, Life Safety Code (2012)
33.3.6.3 Elevators, Dumbwaiters, and Vertical Conveyors.
Elevators, dumbwaiters, and vertical conveyors shall comply with Section 9.4**.**
9.4.6 Elevator Testing.
9.4.6.1 Elevators shall be subject to periodic inspections and tests as specified in ASME A17.1/CSA B44, Safety Code for Elevators and Escalators.
9.4.6.2 All elevators equipped with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASMEA 17.1/CSA B44, Safety Code for Elevators and Escalators.
9.4.6.3 The elevator inspections and tests required by 9.4.6.1 shall be performed at frequencies complying with one of the following:
(1) Inspection and test frequencies specified in Appendix N of ASME A17.1/CSA B44, Safety Code for Elevators and Escalators
(2) Inspection and test frequencies specified by the authority having jurisdiction

Electrical Systems

3. Based on records review, observation, and interview, the facility failed to properly inspect and test all components of the emergency generator and ensure that emergency stop switches were labeled according to the code. The deficient practice affected 13 of 13 smoke compartments, staff, and all residents. The facility had the capacity for 168 beds with a census of 54 on the first day of survey.

The findings include:

Record review, on 7/26/24, at 11:50 a.m., of the monthly emergency generator inspection and testing records dating back 12 months prior to the survey, revealed the facility failed to record emergency generator battery specific gravity values for seven (7) of the 12-month period reviewed as required by section 8.3.7.1 of NFPA 110, Standard for Emergency and Standby Power Systems. Additional record review revealed data entered in the facility records indicated values of "N/A".

An interview, on 7/26/24, at 11:50 a.m., with Maintenance Staff B revealed the facility was unaware that specific gravity testing

	was a monthly requirement, and that the facility was performing specific gravity testing on a quarterly basis. Observation during the facility tour, on 7/26/24, at 12:00 p.m., revealed three (3) 1000-Kilowatt emergency generators, all containing “Maintenance” type lead acid type batteries. The census of 54 was verified by Administrative Staff B on 7/26/24, at 11:30 a.m. The findings were acknowledged by Administrative Staff B and verified by Maintenance Staff A during the LSC exit interview on 7/26/24, at 2:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **33.2.5 Building Services.** **33.2.5.1 Utilities.** Utilities shall comply with Section 9.1. **9.1 Utilities.** **9.1.1 Gas.** Equipment using gas and related gas piping shall be in accordance with NFPA 54, National Fuel Gas Code, or NFPA 58, Liquefied Petroleum Gas Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. **9.1.2 Electrical Systems.** Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. **9.1.3 Emergency Generators and Standby Power Systems.** Where required for compliance with this Code, emergency generators and standby power systems shall comply with 9.1.3.1 and 9.1.3.2. **9.1.3.1** Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. **9.1.3.2** New generator controllers shall be monitored by the fire alarm system, where provided, or at an attended location, for the following conditions: (1) Generator running (2) Generator fault (3) Generator switch in nonautomatic position **9.1.4 Stored Electrical Energy Systems.** Stored electrical energy systems shall be installed, tested, and maintained in accordance with NFPA 111, Standard on Stored Electrical Energy Emergency and Standby Power Systems. **Actual NFPA Standard: NFPA 110, Standard for Emergency and Standby Power Systems (2010)** **8.3.7.1** Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted.

Fire Safety and Operations

4. Based on records review and interview, the facility failed to conduct emergency egress and relocation drills in accordance with the code. The deficient practice affected 13 of 13 smoke compartments, staff, and all residents. The facility had the capacity for 168 beds with a census of 54 on the first day of survey.

The findings include:

Records review, on 7/26/24, at 11:30 a.m., of facility emergency egress and relocation drill reports revealed the facility had not conducted emergency egress and relocation drills no less than six (6) times per year on a bimonthly basis, with two (2) drills conducted during the night when residents were sleeping, as required by section 33.7.3.1 of NFPA 101, Life Safety Code. Additional record review revealed that two (2) emergency egress and relocation drills were conducted 12 months prior to the start of the survey.

An interview, on 7/26/24, at 11:33 a.m., with Administrative Staff D revealed the facility was not aware of the requirement to conduct not less than six (6) exit and relocation drills with two (2) drills conducted during the night when residents were sleeping. Additional interview revealed that the facility was cited for emergency egress and relocation drill noncompliance during the 2023 VA survey, and were instructed by a state agency that they were only required to conduct two exit and relocation drills annually.

The census of 54 was verified by Administrative Staff B on 7/26/24, at 11:30 a.m. The findings were acknowledged by Administrative Staff B and verified by Maintenance Staff A during the LSC exit interview on 7/26/24, at 2:00 p.m.

Actual NFPA Standard: NFPA 101, Life Safety Code (2012)
33.7.3 Emergency Egress and Relocation Drills. Emergency egress and relocation drills shall be conducted in accordance with 33.7.3.1 through 33.7.3.6.
33.7.3.1 Emergency egress and relocation drills shall be conducted not less than six times per year on a bimonthly basis, with not less than two drills conducted during the night when residents are sleeping, as modified by 33.7.3.5 and 33.7.3.6.
33.7.3.2 The emergency drills shall be permitted to be announced to the residents in advance.
33.7.3.3 The drills shall involve the actual evacuation of all residents to an assembly point, as specified in the emergency plan, and shall provide residents with experience in egressing through all exits and means of escape required by this Code.

	33.7.3.4 Exits and means of escape not used in any drill shall not be credited in meeting the requirements of this Code for board and care facilities. **33.7.3.5** Actual exiting from windows shall not be required to comply with 33.7.3; opening the window and signaling for help shall be an acceptable alternative. **33.7.3.6** If the board and care facility has an evacuation capability classification of impractical, those residents who cannot meaningfully assist in their own evacuation or who have special health problems shall not be required to actively participate in the drill.