State Veterans' Homes (SVH) Corrective Action Plan
Charlotte Hall Veterans Home
8/21/23-8/24/2023 Date of Survey

Important: Attestation by the SVH leadership, including the SVH nurse leader, of actions to assure timely completion of goals and establishment of oversight to assure continued improvement in areas identified for correction. The Corrective Action Plan (CAP) should include input from all levels of staff and effected resident(s), as is applicable and appropriate, impacted by the issue identified. This CAP is intended to become a source towards Quality Assurance/Performance Improvement activities (QAPI).

State the Issue **Identify the Standard and Findings**		**Address how corrective action will be accomplished for those residents found to be affected by the deficient practice** (Actions should align with QAPI fundamentals)	**Address how the SVH will identify other residents having the potential to be affected by the same deficient practice**	**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur**	**How does the SVH plan to monitor its performance to make sure that solutions are sustained.** (Actions should align with QAPI)	**Proposed Completion Date**
51.70 (c) (5) Conveyance upon death Upon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 90 calendar days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows. Based on record review and interview, the facility failed to conduct a timely final accounting upon the death of residents with funds deposited in a trust account for three (3) of five (5) sampled accounts (Residents #28, #29 and #30).		Resident #28's representative has been notified to obtain a letter of administration by the business office on 3/1/23 and 4/3/23, the account was closed on July 11, 2023 Resident #29's resident funds have been conveyed and the account has been closed. Resident #30 representative has been notified to obtain a letter of administration by the business office on 11/1/22 and 12/1/22, the account was closed on July 11, 2023	Deceased residents with funds accounts have the potential to be affected. The resident account manager has audited resident personal funds accounts monthly to evaluate completion of conveyance of funds within 90 days of death, 5 accounts were identified and closed.	The resident fund policy was updated to reflect the conveyance of funds upon the death of resident who does not have a responsible party, estate or beneficiary designee. Upon admission and for current residents the resident fund manager or designee will obtain a signed beneficiary designee document. The signature on the Beneficiary Document will be from either the responsible party or the competent resident. The documents will be maintained in the resident's financial records. Upon the death of a resident the funds that reside in the resident financial account held by the facility will be distributed in accordance to the instructions on the beneficiary designee document. In the absence of instructions or not having a responsible party or estate then the funds will be conveyed 30 days after the death of a resident by the business office manager or designee to an outside account referred to as the Escrow Account. The Escrow Account will be managed by the outside management company's financial department's designee. All resident funds conveyed to the	Beginning March 1, 2024, the Resident Account Manager or designee is responsible for auditing all resident fund accounts monthly for three (3) to assure that there is a completed Beneficiary Designee document on file. If one is not found, then the Business Office Manager (BOM) will be notified promptly. The BOM will work with the resident and or responsible party to obtain the completed Beneficiary Designee Document. 2. Beginning March 1, 2024, the Resident Fund Account Manager will conduct a monthly audit for three (3) months of the resident fund accounts. The purpose of the audit is to identify if there are resident funds that have not been conveyed within 30 days of the resident's death to the resident's beneficiary or estate as directed by the resident. If there is not Beneficiary Designee or no direction has been provided by the resident or responsible party on what to do with funds that remain in RFMS after the death of the resident, then those funds will be transferred to an Escrow Account managed by the outside contracted	5/31/2024

				Escrow Account will be held in the account for one year. Any funds that remain in the account for one year will be turned over to the Unclaimed Proper Section, Comptroller of the Treasury of Maryland. If during the one year a beneficiary provides a letter of administration demonstrating that they are legal beneficiation of the estate, then the designee for the financial department will make arrangements to have the funds conveyed to the beneficiary.	company. The Escrow account is a septate account from the resident fund account. The oversight of the account is by the contracted company's financial department's designee. If there is a discrepancy in the conveyance of funds, then the Resident Fund Account Manager will promptly report this to the BOM. The BOM then will work with the Resident Fund Manager to assure that the funds are conveyed according to the Beneficiary designee document or to the Escrow Account. The BOM will obtain from the financial designee of the Escrow Account monthly any activity regarding the conveyance of the funds The BOM will report the activity of the account to the administrator monthly for three (3) months to assure that the funds are being held in the Escrow Account and that they are being conveyed by the one year or at the time a benefactor has presented the letter of administration. Results of these audits will be reported to the Quality Assurance Committee monthly for three (3) months for review and action as appropriate.	
51.100 (i) (2) Environment Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; Based on observations, interviews, record review, and review of the facility policy, the facility failed to maintain a sanitary and clean environment in resident rooms, resident common areas, and other areas inside of the facility.		Rooms 1B105P, 1B118P, 1B110P, 1B117P, 1B124P have been cleaned and treated for pests by the Highland Pest Control Company. A323B has been cleaned by housekeeping staff. 2B day room has been treated for pests by Highland Pest Control Company. 2C day room has been treated for pests by Highland Pest Control Company. 2B dining area day room has been treated for pests by Highland Pest Control Company.	All residents have the potential to be affected	The facility has adopted a new pest control plan with Highland Pest Control. Housekeeping staff have been in-serviced by the Director of Environmental Services regarding cleaning resident room floors, spider webs, and cleaning after meals.	The Director of Maintenance or designee will audit results of treatment for pests weekly for four weeks then monthly for two months Beginning the week of October 18th, 2023. The Director of Environmental Services will audit cleaning of resident room floors, spider webs and cleaning after meals weekly for four weeks the monthly for two months Beginning the week of October 15th, 2023. Results of these audits will be reported to the Quality Assurance Committee for review and action as appropriate.	1/30/2024
51.110 (e) (1) Comprehensive care plans (1) The facility management must develop an individualized comprehensive care plan for each resident that		Resident #16's meal tray was replaced with the ordered diet and fluids were thickened to nectar consistency by nursing and kitchen staff. Resident #16's nutritional	The Unit Manager or designee will audit current residents on mechanically altered diets and on thickened liquids to evaluate whether food and beverages are served in accordance with the diet order	The Kitchen Manager or designee in serviced dietary staff regarding meal tray accuracy and thickened liquids. The RN Clinical Competency Coordinator (CCC) or designee will in-service nursing staff regarding comparing tray delivered to unit to	The Unit Manager or designee will audit thickened liquids served and mechanically altered diets served weekly for four weeks then monthly for two months Beginning the week of October 6th, 2023. The Kitchen Manager or designee will	1/30/2024

includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment. The 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 §51.120; and (ii) Any services that would otherwise be required under §51.120 of this part but are not provided due to the resident's exercise of rights under §51.70, including the right to refuse treatment under §51.70(b)(4) of this part. Based on review of facility policy, record review, and interview, the facility failed develop a Care Plan Focus/Problem to meet the dietary/nutrition needs for one (1) of 30 sampled residents, Resident #16.		care plan was implemented by the Registered Dietitian.	The RN QA Director audited resident diet orders to tray cards to evaluate accuracy. The Registered Dietitian or designee will audit current residents to evaluate implementation of a nutritional care plan.	tray card specifications prior to serving. The DHS or designee will in-service Registered Dietitian's regarding care plan implementation.	audit resident meal trays to evaluate accuracy and thickened liquids are provided from the kitchen in accordance with the diet order weekly for four weeks then monthly for two months Beginning the week of October 23rd, 2023. The Registered Dietitian will audit new admissions and residents with new significant weight changes for care plan implementation weekly for four weeks then monthly for three months Beginning the week of October 2nd, 2023. Results of these audits will be forwarded to the facility QAPI Committee for review and action as appropriate.	
51.110 (e) (2) Comprehensive care plans A comprehensive care plan must be— (i) Developed within 7 calendar days after completion of the comprehensive assessment; (ii) Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and (iii) Periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review, interview with facility staff, and facility policy review, the facility failed to ensure the		Resident #4's Behavior care plan and psychotropic drug use care plan has been revised by the Social Worker. Resident #4's care plan for psychotropic medications has been revised by the MDS Coordinator.	The Director of Social Work or designee will audit current residents with behavior care plans to evaluate interventions for psychiatric medication adjustment follow up revision. The Unit Manager or designee will audit care plans of residents currently receiving the antipsychotic class of medication to evaluate potential side effects are included on the care plan.	The Director of Social Work or designee will in-service Social Work staff regarding interventions for psychiatric medication adjustment follow up revision The CCC will in-service unit managers regarding care plan revision for antipsychotic medications, and potential side effects.	The Director of Social Work will audit current residents with psychotropic medications and their behavior care plans to evaluate whether potential side effects of antipsychotic class of medication are included on the care plan. The audits will be weekly for four weeks then monthly for two months Beginning the week of October 2nd, 2023. Results of these audits will be forwarded to the facility QAPI Committee for review and action as appropriate The Director of Health Services (DHS) or designee will audit current residents with psychotropic medications and their behavior care plans to evaluate whether potential side effects of antipsychotic class of medication are included on the care plan weekly for four weeks then monthly for two months Beginning the week of October 2nd, 2023. Results of these audits will be forwarded to the facility QAPI Committee for review and action as appropriate	1/30/2024

comprehensive Care Plan was reviewed and revised to reflect the current status for antipsychotic medications for one (1) resident of four (4) residents whose medications were reviewed for use of psychotropic medications (Resident #4).						
51.110 (e) (3) Comprehensive care plans The services provided or arranged by the facility must— (i) Meet professional standards of quality; and(ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, staff interviews, record review, and review of the facility policy, the facility failed to administer and document a medication properly for one (1) resident (Resident #13).		Resident #13 is receiving Famotidine as ordered. LPN A's agency contract was cancelled 8/22/2023.	The Unit Manager or designee will audit current residents with enteral tubes to evaluate whether ordered medications are on hand for administration and enteral tube medication and administration documentation	The CCC will in-service licensed nurses regarding enteral tube medication administration guidelines and actions to take if a medication is unavailable	The unit manager or designee will audit residents with enteral tubes for medication availability and enteral tube medication administration documentation weekly for four weeks then monthly for two months Beginning the week of October 5th, 2023. Results of these audits will be forwarded to the facility QAPI Committee for review and action as appropriate	1/30/2024
51.125 (h)Enteral Feedings Based on the comprehensive assessment of a resident, the facility management must ensure that— (1) A resident who has been able to adequately eat or take fluids alone or with assistance is not fed by enteral feedings unless the resident's clinical condition demonstrates that use of enteral feedings was unavoidable; and (2) A resident who is fed by enteral feedings receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers and other skin breakdowns, and to restore, if possible, normal eating skills. Based on observation, staff interview, record review, and review of facility policy, the facility failed to ensure that		LPN A's agency contract was cancelled 8/22/2023.	The Unit Manager or designee will audit medication administration technique of licensed nurses to evaluate whether medications are administered without use of the syringe plunger	The CCC or designee will in-service licensed nurses regarding enteral tube medication administration guidelines.	The unit manager or designee will audit residents with enteral tubes during medication administration to evaluate whether medications are administered without use of the syringe plunger weekly for four weeks then monthly for two months Beginning the week of October 6th, 2023. Results of these audits will be forwarded to the facility QAPI Committee for review and action as appropriate	1/30/2024

medications per gastrostomy tube (g-tube) were administered per the facility policy for one (1) resident (Resident #13).						
51.120 (j)Nutrition Based on a resident's comprehensive assessment, the facility management must ensure that a resident— (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when a nutritional deficiency is identified Based on record review, observation, and interview, the facility failed to follow dietary orders for one (1) of 30 sampled residents, Resident #16.		Resident #16's care plan for nutrition has been revised by the dietitian	The Registered Dietitian (RD) or designee will audit current residents to evaluate implementation of a nutrition care plan. The Unit Manager or designee will audit current residents with mechanically altered diets and thickened liquids to evaluate whether food and beverages are served in accordance with the diet order.	The Kitchen Manager or designee in serviced dietary staff regarding meal tray accuracy and thickened liquids. The RN CCC or designee will in-service nursing staff regarding comparing tray delivered to unit to tray card specifications prior to serving. The DHS or designee will in services RDs regarding implementation of a nutrition care plan for current residents.	The Registered Dietitian (RD) or designee will audit current residents to evaluate implementation of and/or needed revisions of a nutrition care plan. Weekly for four weeks then monthly for two months Beginning the week of October 2nd, 2023. The Unit Manager or designee will audit current residents with mechanically altered diets and thickened liquids to evaluate whether food and beverages are served in accordance with the diet order weekly for four weeks then monthly for two months Beginning the week of October 6th, 2023. The Kitchen Manager or designee will audit resident meal trays to evaluate accuracy and thickened liquids are provided in accordance with the diet order weekly for four weeks then monthly for two months Beginning the week of October 23rd, 2023. Results of these audits will be forwarded to the facility QAPI Committee for review and action as appropriate	1/30/2024
51.120 (n)Medication errors The facility management must ensure that— (1) Medication errors are identified and reviewed on a timely basis; and strategies for preventing medication errors and adverse reactions are implemented. Based on observation, staff interview, record review, and review of facility policy, the facility failed to ensure that medications were administered as ordered for one (1) resident (Resident #13) by one staff for two (2) of 28 medication administration opportunities.		Resident #13 is receiving Famotidine as ordered. LPN A's agency contract was cancelled 8/22/2023.	The Unit Manager or designee will audit current residents with enteral tubes to evaluate whether enteral tube medication administration and documentation are completed as ordered.	The CCC will in-service licensed nurses regarding actions to take if a medication is unavailable	The unit manager or designee will audit residents with enteral tubes for medication availability weekly for four weeks then monthly for two months Beginning the week of October 6th, 2023 Results of these audits will be forwarded to the facility QAPI Committee for review and action as appropriate.	1/30/2024
51.140 (h)Sanitary conditions The facility must: (1) Procure food from sources approved or		The kitchen was treated for flies and gnats on 8/24/2023 by kitchen staff The kitchen drink machine area was cleaned and	All residents have the potential to be affected.	The facility has adopted a new pest control plan with Highland Pest Control. The Kitchen Manager or designee in serviced the cook/prep staff regarding	The Kitchen Manager or designee will audit kitchen areas for presence of pest and report observations if treatment are effective to the director of maintenance for immediate action weekly for 4	1/30/2024

considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly. Based on observations, interviews, record review, and review of the facility policy, the facility staff failed to store, prepare, and serve food under sanitary conditions. Additionally, the facility failed to maintain an effective pest control program to eliminate the insects observed in the main kitchen. This failure placed 186 residents who receive food from the facility kitchen to be at risk for foodborne illnesses.		treated for flies and gnats on 8/24/2023 by kitchen staff. The Head Chef intervened and directed the cook back to the prep area and the Head Chef took over the veal. Food thermometers are being sanitized between uses and/ or food items.		covering food items and the slicer during preparation time if the employee must walk away from the prep area. The Kitchen Manager or designee in serviced kitchen staff regarding sanitizing food thermometers between uses/food items.	weeks then monthly for two months Beginning the week of October 15th, 2023. The Kitchen Manager or designee will conduct observations of cooks and/or prep staff preparing food item to evaluate whether food is covered any time the employee walks away from the prep task weekly for four weeks then monthly for two months Beginning the week of October 23rd, 2023. The Kitchen Manager or designee will conduct observations of kitchen staff obtaining temperatures of food to evaluate whether food thermometers are sanitized between uses/food items weekly for four weeks then monthly for two months Beginning the week of November 7th, 2023. Results of these audits will be forwarded to the facility QAPI Committee for review and action as appropriate	
51.190 (a) Infection control program The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection control program. The facility management must establish an infection control program under which it— (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. Based on observations, staff interviews, and review of the facility's policies, the facility failed to ensure staff followed appropriate infection control processes to prevent the potential spread of infection. Specifically, the facility failed		Resident #19's Covid-19 precautions have been discontinued. LPN A 's agency contract was cancelled 8/22/2023. Bleach dilution test strips have been obtained for housekeepers use.	Residents residing on unit 3C have the potential to be affected.	The CCC or designee will in-service nursing staff regarding hand hygiene, donning, doffing and disposal of personal protective equipment (PPE), handling dishware for residents on Covid-19 precautions and placement of trash cans for residents on Covid-19 precautions. The Infection Control Preventionist (ICP) or designee will in-service housekeeping staff regarding and contact times for sanitization and using test strips for evaluating bleach dilution for cleaning and sanitization.	The Infection Preventionist or designee will conduct weekly observations of residents on contact precautions for Covid-19 to evaluate staff practices of regarding hand hygiene, donning, doffing and disposal of personal protective equipment, trash can placement and handling dishware for residents on Covid-19 precautions Beginning the week of October 6th, 2023 Weekly for four weeks then monthly for two months. The ICP or designee will conduct weekly observations of housekeeping staff cleaning rooms of residents with Covid-19 to evaluate adherence to contact times for cleaning and sanitization of surfaces and utilization of bleach dilution test strips Beginning the week of October 13th, 2023 weekly for four weeks then monthly for two months. Results of these audits will be forwarded to the facility QAPI Committee for review and action as appropriate.	1/30/2024

to ensure staff followed effective donning and doffing processes of Personal Protective Equipment (PPE) for residents on enhanced barrier precautions and COVID-19 isolation on two (2) of three (3) resident floors.						
51.200 (a) Life safety from fire (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. Means of Egress 1. Based on records review and interview, the facility failed to document the annual tests of the battery powered emergency lights. The deficient practice affected two (2) of 30 smoke compartments, staff, and no residents. The facility had a capacity for 318 beds with a census of 189 on the day of the survey.		1C staff have been in-serviced regarding the fence lock box code to open the courtyard gate by the Director of Safety and Security. The kitchen hood was inspected on 9/5/2023 The equipment located under the kitchen hood was secured on 9/10/2023 by maintenance staff Smoke sensitivity testing for smoke detectors has been added to the new vendor contract for Pruitt Health. Testing was completed by Dynalectric on 9/28/2023	All residents have the potential to be affected.	1C staff have been in-serviced regarding the fence lock box code to open the courtyard gate by the Director of Safety and Security and the 1C unit manager. The 1C fence lock box code has been added to the 1C Emergency Procedures Manual located on 1C. The kitchen hood inspection dates have been entered into the TELS system for ongoing completion by the Director of Maintenance. The Kitchen Manager has been in-serviced by the LNHA or designee to notify maintenance via the TELS system to secure any moved appliances to the approved designated location after cleaning or service. Smoke sensitivity testing for smoke detectors has been added to the TELS system by the Director of Maintenance or designee.	The CCC has added the 1C fence lock box code to orientation for newly hired employees. The Director of Maintenance or designee will audit the TELS system monthly for inspections due to evaluate completion of the Kitchen Hood Inspection Beginning the week of October 16th, 2023. The Kitchen Manager or designee will audit kitchen appliances that have been cleaned or serviced to evaluate secure replacement to their approved designated location weekly for four weeks then monthly for three months Beginning the week of October 31st, 2023. The Director of Safety and Security will audit the TELS system monthly for testing due and contact any contractors without planned inspection dates to evaluate whether inspections are completed within designated timelines Beginning the week of October 16th, 2023. If any contractor is identified as outside of the designated timeline the contractor will be contacted and the LNHA will be notified. These audits will be completed weekly for four weeks then monthly for two months. Results of these audits will be forwarded to the facility QAPI Committee for review and action as appropriate	1/30/2024
51.200 (b) Emergency Power (1) An emergency electrical power system must be provided to supply power adequate for illumination of all exit signs and lighting for the means of egress, fire alarm and medical gas alarms, emergency communication systems, and generator task illumination. (2) The system must be the appropriate type essential electrical system in accordance with the applicable provisions of NFPA 101, Life Safety Code and NFPA 99,		Generator load bank testing is currently scheduled to begin 10/23/23.	All residents have the potential to be affected.	Generator load bank testing has been added to the TELS system for ongoing completion by the Director of Maintenance.	The Director of Maintenance or designee will audit the TELS system monthly for testing due and contact any contractors without planned testing dates to evaluate whether tests are completed within designated timelines Beginning the week of October 16th, 2023 If any contractor is identified as outside of the designated timeline the contractor will be contacted and the LNHA will be notified. These audits will be completed weekly for four weeks then monthly for two months. Results of these audits will be forwarded to the facility QAPI Committee for review and action as appropriate.	1/30/2024

Health Care Facilities Code. (3) When electrical life support devices are used, an emergency electrical power system must also be provided for devices in accordance with NFPA 99, Health Care Facilities Code. (4) The source of power must be an on-site emergency standby generator of sufficient size to serve the connected load or other approved sources in accordance with NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. Based on records review and interview, the facility failed to properly inspect and test all components of the emergency generator. The deficient practice affected 30 of 30 smoke compartments, staff, and all residents. The facility had the capacity for 318 beds with a census of 189 on the first day of survey.						
51.200 (h) (4) Other environmental conditions Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observations, interviews, and record review, the facility management failed to maintain an effective pest control program. This failure placed 189 out of 189 residents at risk.		The facility has adopted a new pest control plan with Highland Pest Control.	All residents have the potential to be affected.	The facility has adopted a new pest control plan with Highland Pest Control.	The Director of Maintenance or designee will inspect areas treated for pests to evaluate whether treatment was effective and complete any follow intervention as needed weekly for four weeks then monthly for two months Beginning the week of October 13th, 2023. Results of these audits will be forwarded to the facility QAPI Committee for review and action as appropriate	1/30/2024
51.210 (b) Disclosure of state agency and individual responsible for oversight Disclosure of State agency and individual responsible for oversight of facility. The State must give written notice to the Office of Geriatrics and Extended Care, VA Headquarters, 810 Vermont Avenue, NW, Washington, DC 20420, at the time of the change, if any of the following		The Maryland Department of Veterans Affairs notified the Veterans Administration of changes to facility operation, administrator, director of nursing and State Representative on 8/24/2023.	All residents have the potential to be affected.	The Maryland Department of Veteran's notified the Veterans Administration of changes to facility operation, administrator, director of nursing and State Representative on 8/24/2023	The Licensed Nursing Home Administrator or designee will audit for completion of notification to the Office of Geriatric and Extended Care National Program Manager any time there is a change in state agency and individuals responsible for oversight of the facility weekly for four weeks then monthly for three months Beginning the week of November 8th, 2023. Results of these audits will be forwarded to the Best Practices Committee for review and action as appropriate.	1/30/2024

change: (1) The State agency and individual responsible for oversight of a State home facility; (2) The State home administrator; (3) The director of nursing services (or other individual in charge of nursing services); and (4) The State employee responsible for oversight of the State home if a contractor operates the State home. Based on review of facility documents and interview, the facility failed to notify the Veterans Administration (VA) of changes to the Facility Operator, Administrator, Director of Nursing, and State Representative affecting 189 of 189 residents.						
§ 51.210 (c) (7) Required Information. Annual State Fire Marshall's report; Based on records review and interview, the facility failed to provide an annual report from the State Fire Marshal. The deficient practice affected 30 of 30 smoke compartments, staff, and all residents. The facility had the capacity for 318 beds with a census of 189 on the first day of survey.		The Fire Marshal inspection was complete 9/6/2023.	All residents have the potential to be affected.	The director of maintenance or designee has entered fire inspection in the facility TELs system to maintain compliance.	The Director of Maintenance or designee will audit the TELS system monthly for inspections due and contact any contractors/vendor without planned testing dates to evaluate whether tests/inspections are completed within designated timelines Beginning the week of October 16th, 2023. If any contractor is identified as outside of the designated timeline the contractor will be contacted and the LNHA will be notified. These audits will be completed weekly for four weeks then monthly for two months. Results of these audits will be forwarded to the facility QAPI Committee for review and action as appropriate	1/30/2024
51.210 (j) Credentialing 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		The eight providers have been credentialed.	The Director of Medical Records has audited all providers credential documents to evaluate completion in accordance with VA and Pruitt Health requirements.	The LNHA or designee has in-serviced the Director of Medical Records regarding the VA and Pruitt Health provider credentialing process. The facility has implemented a new provider Pruitt Health credentialing platform effective 10/15/2023. The Pruitt Health credentialing department generates the OIG reports quarterly for providers. If there is a concern, then they notify the facility upon discovery. Any new providers to Charlotte Hall Veterans home will be required to be compliant with the new platform credentialing verification process.	The Director of Medical Records or designee will audit new credentialing applications to evaluate whether required documentation is received and submitted to the platform prior to starting service. Any applicant who is found to be missing information will not be permitted to start and reported to the Administrator weekly for four weeks then monthly for two months Beginning the week of October 20th, 2023. After initial credentialing the credentialing platform the Pruitt Health Credentialing department will provide the facility up to date credential verification on a quarterly basis. The Medical Director and	1/30/2024

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 independent practitioner practicing within the facility. (5) When reappointing a licensed independent practitioner, the facility management must review the individual's record of experience. The facility management systematically must assess whether individuals with clinical privileges act within the scope of privileges granted. Based on interview and record review, the facility failed to maintain current and complete credentialing and privileging records for eight (8) of eight (8) Licensed Practitioners who provided care to the residents.				The credentialing program tracks critical provider changes in status promoting effective provider management. On an ongoing basis the Pruitt Health credentialing department will generate the OIG reports quarterly for providers. If there is a concern, then they notify the facility upon discovery. Prospective providers applying for privileges at Charlotte Hall Veterans Home will only be considered for privileges within the licensed scope of practice.	Administrator will review credentials of providers regarding practicing within their scope of practice quarterly and ongoing. Results of these audits will be forwarded to the Quality Assurance Committee for review and action as appropriate.	