STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215223	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlestown Community Inc	719 Maiden Choice Lane Catonsville, MD 21228

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 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 interviews it was determined that the facility failed to appropriately prescribe a psychotropic medication for a resident without a documented need for one and monitor for behaviors and side effects. This was found evident in 3 (Resident #11, #67, & #84) out of 6 residents reviewed for unnecessary medications.The findings include:Chemical restraint is the use of drugs to restrict a person's freedom of movement or control their behavior, and it is not a standard treatment for their medical or psychiatric condition. It is a controversial practice that is heavily regulated and can be considered a form of abuse when misused. A chemical restraint is a form of medical restraint in which a drug (medication) is used to restrict the freedom of movement of a person or in some cases to sedate the person. An example of a chemical restraint includes benzodiazepines (such as Ativan and Xanax) which are fast-acting sedatives used for anxiety and agitation. These drugs are used primarily to control or restrict a person's behavior rather than treat an underlying condition. These medications, when used with the main intent of reducing agitation or movement, function as chemical restraints, even if they also have other therapeutic purposes. A drug used for chemical restraint may also be referred to as a psychotropic drug or therapeutic restraint. Psychotropic medications are used to treat mental health disorders and are considered any drug that affects behavior, mood, thoughts, or perception. There are five main types of psychotropic medications, and each type has its own specific uses, benefits, and side effects. The five main types are: antidepressants, anti-anxiety, stimulants, antipsychotics and mood stabilizers.1a) On 9/16/25 at 9:12 AM, the surveyor reviewed Resident #11's medical record. The review revealed that Resident #11 was prescribed Seroquel (also known as Quetiapine, an antipsychotic medication that treats several kinds of mental health conditions) for destressing delusional thoughts on 4/6/24 and Remeron (also known as Mirtazapine, an antidepressant) for adjustment disorder starting 11/2/23. The surveyor next reviewed Resident #11's psychiatric notes written by Clinical Nurse Specialist Staff #21. In a note dated 12/20/24 Staff #21 wrote, a Gradual Dose Reduction (GDR) is contraindicated as Resident # 11 continues to have distressing delusional thoughts and Quetiapine is at the lowest dose possible that has helped to decrease some of the distress. Staff #21 assessed Resident #11 on 2/21/25, 4/18/25, and 7/11/25. In both note on 2/21/25 and 4/18/25 Staff #11 documented that Resident #11 did not express delusional thoughts that day however continued to have episodes. On 7/11/25 Staff #21 wrote that Resident # 11 was tolerating Quetiapine as prescribed suggesting continuing the dose and that the Resident was continuing to have distressing delusional thoughts. The surveyor reviewed the Minimum Data Set (MDS) assessments for Resident #11 during the assessments with an Assessment Reference Dates (ARD) of 10/4/24, 1/4/25, 4/4/25 and 7/8/25. No, was marked for hallucinations and No, was marked for delusions in all of the assessments noted above. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/16/25 the surveyor interviewed Minimum Data Set Coordinators #18 & #19 along with the Director of Nursing (DON). Staff #18 stated that behaviors are coded on the assessment when the behaviors are noted in the medical records, in both nursing and/or provider notes within the look back period. The surveyor expressed the concern that the rationale given by Staff #21 for the continuation and contraindication for reduction of Quetiapine was noted delusional behaviors. The surveyor requested any documented behaviors noted for Resident #11. On 9/16/25 at 12:10 PM, the surveyor conducted an interview with Staff #21. During the interview Staff #21 stated that when a Resident is on a psychotropic medication it would be her expectations that behaviors are monitored. She further stated that when she evaluates if behaviors are happening, she would look through notes and speak to the staff about behaviors. The surveyor relayed the concern that the only behaviors noted in the medical record were from the ones written in her evaluation. She confirmed that she did not document the behaviors described by staff when asked. At the time of exit no evidence that Resident #11 was having behaviors was provided even though it was the rationale for continuing to prescribe a psychotropic medication and rationale for not titrating a gradual dose reduction. 1b) The surveyor conducted a record review of Resident #67's medical record on 9/17/2025 at 9:30 AM. Review of the medical record revealed that Resident #67 had a physician order since 8/11/2025 for Alprazolam (Xanax) 0.25 mg oral tablet one time daily as needed (PRN) for agitation and anxiety. Further review of the medical record revealed that Resident #67 was administered Xanax daily for 6 days in August on 8/14/2025, 8/19/2025, 8/22/2025, 8/24/2025, 8/28/2025 and 8/29/2025 and for 5 days in September on 9/4/2025, 9/5/2025, 9/6/2025, 9/7/2025 and 9/12/2025. Also, the physician order for Alprazolam (Xanax) did not include the duration/time frame for the usage of this psychotropic medication that was prescribed as needed (PRN). At 12:05 PM on 9/18/2025 the surveyor interviewed the Director of Nursing (DON) regarding the physician order for Alprazolam (Xanax) daily as needed (PRN) for Resident #67 that did not include the duration/time frame for the usage. The surveyor reviewed the PRN Xanax order with the DON. The surveyor confirmed with the DON that Xanax was ordered originally on 8/11/2025 and that Resident #67 had not received this medication prior to this date in the facility. The surveyor conveyed to the DON that the PRN Alprazolam (Xanax) order did not have a duration/time frame for usage. The DON acknowledged the surveyor. The surveyor asked the DON what the expectation was for duration/time frame for usage of PRN (as needed) psychotropic medications, such as Xanax. The DON stated that there should be a duration/time frame included in the physician order for usage of PRN Xanax. The surveyor clarified that psychotropic medications such as Alprazolam (Xanax) which were ordered as needed (PRN) were to be limited to 14 days, unless the prescribing practitioner documented a rationale to extend the medication. Additionally, the surveyor conveyed to the DON that there was insufficient documentation of ongoing monitoring of behaviors and symptoms for the usage of Alprazolam (Xanax). The DON acknowledged the surveyor and stated that the facility was in the process of educating the licensed nurses on the monitoring and documentation of behaviors and symptoms for the usage of psychotropic medications. At the time of survey exit, no additional information was provided by the facility regarding psychotropic medications. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1c) On 09/17/25 at 11:30 AM a review of Resident #84 medication administration record revealed the resident was prescribed Seroquel 12.5 mg by mouth (PO) every hour of sleep related to Dementia with Psychotic Disturbance. On 12/10/24 the medication was increased to Seroquel 25 mg PO every hour of sleep R/T the resident had visual hallucinations. The surveyor was unable to locate documentation to verify the nurses were monitoring the resident for extrapyramidal side effects of the medication or documenting when the resident had behaviors that would indicate the dose of the medication may need to be adjusted. Further review of the electronic medical record revealed the psychotropic medication was increased on 01/30/25 to Seroquel 37.5 mg PO every hour of sleep. There was no documentation to indicate why the medication was increased and if the staff was monitoring behaviors or side effects. On 09/17/2025 at 2:03 PM during an interview with the Director of Nursing (DON) #2, he/she verbalized they have a behavioral monitoring system where the Geriatric Nursing Assistants use a touch system where they document what they see. If there was any negative action or expression displayed the system would prompt them to answer more questions. The surveyor made DON #2 aware that if a nurse is assigned a resident who is prescribed psychotropic medication they are required to monitor the resident for behaviors and extrapyramidal side effect. The prescribing clinician should have that information available to determine if the medication is working or needs to be adjusted. On 09/17/2025 at 3:37 PM the surveyor reported to Administrator #1 the nurses are not monitoring residents prescribed psychotropic medications for extrapyramidal side effects and not monitoring the resident for behaviors. Administrator #1 verbalized they have high risk rounds weekly which include residents who are prescribed psychotropic medications. They are going to work on having more precise documentation instead of generic documentation. On 09/18/2025 at 11:05 AM DON #2 verbalized the resident goes to see a Neurologist at John Hopkins Hospital for Huntington's Disease and the Neurologist made the recommendation to increase the medication to Seroquel 37.5 mg R/T moderate Dementia with psychotic disturbance. The surveyor asked what warranted the increase of the medication. DON #2 verbalized the resident was having hallucinations; they don't have documentation specific to that nature. Yes, they could have had documentation. They meet on a weekly basis and talk about the residents who are prescribed psychotropic medications.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews it was determined that the facility staff failed to complete a thorough investigation of facility reported incidents as evidenced by not including statements from all staff who worked during the time the alleged incidents occurred. This deficient practice was evidenced in 2 (#36, #98) of 5 facility reported incident investigations reviewed during the recertification survey. The findings include: On 09/16/2025 at 2:44 PM a review of the facility's investigation of the facility reported incident #325365 related to an allegation of abuse associated with Resident #36 revealed there were no statements from all staff who worked during the time of the alleged incident. On 09/16/25 at 11:15 AM during an interview with Assistant Nursing Home Administrator #3 the surveyor asked how did they determine who should be interviewed concerning the allegation? He/she verbalized after the alleged perpetrator was interviewed, the nursing supervisor, and the assigned nurse were interviewed. Also, statements were taken from people who worked on 03/10/25. The surveyor requested a copy of the staffing sheets for the date and shift when the alleged incident occurred. At 12:00 PM a review of the staffing sheet for [NAME] Overlook 2 dated 03/10/25 3:00 pm - 11:00 pm revealed Geriatric Nursing Assistants #8, #9, #10, and #11 were included on the staffing sheet but a statement from the GNA's were not included with the investigation. On 09/16/25 at 2:48 PM the surveyor reported to Assistant Nursing Home Administrator #3 there were not statements from all the staff who worked on 03/10/25 during the 3:00 pm - 11:00 pm shift when the alleged allegation of abuse was reported. Assistant Nursing Home Administrator #3 verbalized statements are taken on a case-by-case basis & they use a clinical rationale for everything. Often the staff may not have a statement, and they were more concerned about getting a summarization of interviews. The surveyor verbalized there were no statements from four GNA's and 1 nurse who worked in the neighborhood when the alleged incident occurred. There were interviews from seven other staff who were not included on the assignment sheet. On 09/18/25 at 10:31 AM a review of the facility's investigation related to the Facility Reported Incident (FRI) #325310 related to an allegation of abuse concerning Resident #98 revealed, a statement from all the staff who worked on [NAME] Overlook 2 on 07/13/23 during 7:00 am - 3:30 pm was not included in the investigation. There was not a statement from Licensed Practical Nurse (LPN) #30 who was assigned to the resident nor was there a statement from GNA #31 who worked when the alleged incident occurred. On 09/18/25 at 11:46 am the surveyor reported to Administrator #1 a thorough investigation was not completed because all the staff who worked during the alleged incident were not interviewed.