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	05/06/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, record review, document review, and facility policy review, the facility failed to timely report an allegation of sexual abuse and an allegation of neglect to the state survey agency for 2 (Resident #1 and Resident #2) of 4 sampled residents reviewed for abuse/neglect. Findings included: A facility policy titled, Abuse Prevention, dated 05/2021, indicated, ii. Timing 1. Alleged allegations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or results in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities). 1. A Face Sheet revealed the facility admitted Resident #1 on 12/23/2025. According to the Face Sheet, the resident had a medical history that included a diagnosis of Alzheimer's disease, dementia with psychotic disturbances, and delusional disorders. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/29/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. During an interview on 05/05/2026 at 3:47 PM, the Occupational Therapist (OT) stated as she evaluated Resident #1 on 12/26/2026, the resident told her that someone touched them inappropriately. The OT stated she immediately informed Registered Nurse (RN) #10. Resident #1's Clinical Notes Report, electronically signed by RN #10 and dated 12/26/2025 at 12:48 PM, indicated Resident #1 reported to an OT that someone was touching [him/her], and gestured toward their private area. Per the Clinical Notes Report, a head-to-toe skin assessment was completed, and the resident was found not to have any visible injuries, redness, bruising, or signs of trauma and denied pain or discomfort. During an interview on 05/05/2026 at 10:25 AM, RN #10 stated an OT came to her on 12/26/2025 and informed her that Resident #1 stated someone touched their private parts. RN #10 stated she informed the administration immediately and was told to assess the resident. During an interview on 05/05/2026 at 3:47 PM, the Director of Nursing (DON) stated it was his expectation that any allegation of abuse be submitted in a timely manner. The DON stated the allegation should have been reported to the state survey agency on 12/26/2025 when the nurse was informed of the alleged incident; however, the allegation was not reported until 01/05/2026. During an interview on 05/05/2026 at 3:50 PM, the Director stated he would have expected the allegation of abuse to be reported in a timely manner. The Facility Reported Incident [FRI] Initial Report Form, indicated the facility reported an allegation of sexual abuse to the state survey agency on 01/05/2026. Per the FRI Initial Report, Resident #1 alleged on 12/26/2025, a female staff member entered their room and began to touch them inappropriately. 2. A Face Sheet revealed the facility admitted Resident #2 on 11/12/2024. According to the Face Sheet, the resident had a medical history that included a diagnosis of senile degeneration of the brain, palliative care, type 2 diabetes mellitus, chronic kidney disease, and urinary tract infection. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/21/2026, revealed Resident #1 had a (continued on next page)

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. Email correspondence from Resident #2's Power of Attorney (POA) addressed to the Director and dated 03/23/2026 at 6:33 PM, indicated the POA had concerns of neglect. The Facility Reported Incident [FRI] Initial Report Form, indicated on 03/23/2026 at 9:00 AM, the Director was made aware of an incident/allegation. Per the FRI Initial Report Form, Resident #2's POA made the Director aware of the allegation of neglect, specifically an allegation of inattentive care that led to the resident being hospitalized . Email correspondence indicated that the Assistant Administrator reported the allegation of neglect to the state survey agency on 03/24/2026 at 7:09 PM. During an interview on 05/06/2026 at 1:00 PM, the Assistant Administrator stated his expectation would be that any allegation of neglect be reported in a timely manner.

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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. Based on interview, record review, document review, and facility policy review, the facility failed to thoroughly investigate an allegation of sexual abuse for 1 (Resident #1) of 4 sampled residents reviewed for abuse/neglect. Findings included: A facility policy titled, Abuse Prevention, dated 05/2021, indicated, 5. Investigation a. The community will investigate all suspected or alleged incidents of resident abuse, mistreatment, neglect, exploitation, involuntary seclusion, including injuries of unknown source and misappropriation of property. A Face Sheet revealed the facility admitted Resident #1 on 12/23/2025. According to the Face Sheet, the resident had a medical history that included a diagnosis of Alzheimer's disease, dementia with psychotic disturbances, and delusional disorders. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/29/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. Resident #1's Clinical Notes Report, electronically signed by Registered Nurse #10 and dated 12/26/2025 at 12:48 PM, indicated Resident #1 reported to an Occupational Therapist that someone was touching [him/her], and gestured toward their private area. Per the Clinical Notes Report, a head-to-toe skin assessment was completed, and the resident was found not to have any visible injuries, redness, bruising, or signs of trauma and denied pain or discomfort. A review of the facility investigation file revealed no evidence to indicate that all staff that had access to Resident #1's room were interviewed. Per the facility investigation file, only two residents who had intact cognition were interviewed; the facility did not include assessments of resident who were cognitively impaired. During an interview on 05/04/2026 at 10:40 AM, the Assistant Administrator stated the facility did interview two alert and oriented residents who resided in the general area of Resident #1's room after the incident and those residents had no concerns. Per the Assistant Administrator, the remainder of the residents were cognitively impaired. When asked if the facility had done any assessment of residents who were cognitively impaired, the Assistant Administrator stated the facility did not do any type of assessments on the residents who were cognitively impaired and he could see why that would be a good idea. During an interview on 05/04/2026 at 12:45 PM, the Director stated usually the facility would interview residents who were cognitively intact and residents who were cognitively impaired would be assessed. During a follow-up interview on 05/06/2026 at 1:00 PM, the Assistant Administrator stated the facility did not assess cognitively impaired residents when the allegation of abuse was made but interviewed cognitively intact residents since they could tell them if they experienced anything related to abuse/neglect. The Assistant Administrator stated only nursing and dietary staff were interviewed; however, the facility should have interviewed all staff that had access to the resident to include housekeeping and therapy staff.