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

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Charlestown Community Inc	719 Maiden Choice Lane Catonsville, MD 21228

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 observation, staff interviews and surveyor record review it was determined that the facility failed to ensure sanitary and safe food service practices. This was found to be evident in 1 out of 2 nourishment refrigerators on the nursing units and in the kitchen. The findings include:On the initial tour of the kitchen at 8:35 AM on 9/15/2025 with the Food Services Director (FSD) in attendance, the surveyor reviewed the dish machine temperature log for the month of September 2025. The surveyor observed that the dish machine temperature log did not have wash temperatures recorded for 9/12 PM, 9/13 PM, and 9/14 PM, and did not have rinse temperatures recorded for 9/2 PM, 9/12 PM, 9/13 midday, 9/13 PM, and 9/14 PM. Additionally, the surveyor reviewed the pot sink sanitizer log for the month of September 2025 and observed that the wash temperature for 9/2 was not recorded for PM, and that the wash and rinse temperatures for 9/4 were not recorded for PM. In an interview with the Food Services Director (FSD) during the initial tour, the surveyor asked what the expectation was for recording the wash and rinse temperatures for the dish machine and the pot sink sanitizer on the log. The FSD stated that the expectation was for the wash and rinse temperatures to be taken AM, midday and PM and recorded on the logs by the dietary staff.At 9:15 AM on 9/15/2025 the surveyor observed the 1st floor nourishment refrigerator with the Food Services Director (FSD) in attendance. The surveyor reviewed the refrigerator and freezer log that was posted for the month of September 2025. The surveyor observed that the log did not have temperatures recorded for 9/2, 9/3, 9/6, 9/7, 9/9 and 9/12 for the refrigerator and freezer. In an interview with the Food Services Director (FSD) at 9:20 AM on 9/15/2025 the surveyor asked what the expectation was for recording the temperatures for the nourishment refrigerator and freezer on the log. The FSD stated that the nursing staff was responsible for monitoring the nourishment refrigerators and freezers on the units and recording the temperatures daily on the log. Additionally, the FSD stated that the nourishment refrigerators and freezers on the nursing units were for the storage of food and beverages for Residents brought in from the outside by family and visitors.

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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(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. 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 (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review, and interview, it was determined the facility failed to provide the resident's representative with a written notice of reason for transfer. This was found evident of 1 (Resident #92) of 4 residents reviewed for hospitalization during the survey. The findings include: On 9/18/25 at 12:10 AM, the surveyor reviewed Resident #92's medical record. The review revealed that Resident #92 went to the hospital in mid June of 2025. Next the surveyor requested the notice for bed hold and reason for transfer notifications. On 9/19/25 the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the NHA provided the bed hold notice give to Resident #92's Representative however, stated that he was not able to find the written notice with reason for transfer. He further stated that the facility had a form for this notice but was not able to explain why it was not utilized

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and surveyor record review, it was determined that the facility failed to complete a Minimum Data Set (MDS) assessment accurately for a Resident. This was found to be evident in 1 (Resident #27) out of 36 Residents reviewed for accuracy of MDS assessments. The findings include: Minimum Data Set (MDS) assessment is a standardized, comprehensive collection of demographic and clinical information about a person's condition, used to facilitate individualized care planning, monitor quality, and support reimbursement in healthcare. The MDS assessment is a federally mandated process by the Centers for Medicare and Medicaid Services (CMS) for clinical assessment of all Residents in Medicare and Medicaid certified nursing homes. The core principle is to gather essential information about patient needs and care. The surveyor conducted a record review of Resident #27's medical record on 9/17/2025 at 9:15 AM. Resident #27 was admitted to the facility on [DATE]. Review of the medical record revealed that Resident #27 had a diagnosis of major depressive disorder as noted in the admitting diagnoses section of the Resident's chart and had an active physician order for Fluoxetine 40 mg capsule oral one time daily for depression as of 5/22/2025. Fluoxetine is an antidepressant drug by pharmacological classification. Further review of Resident #27's medical record revealed that Resident had an active physician order for gabapentin 100 mg capsule oral hour of sleep for neuropathy pain as of 5/22/2025. Gabapentin is an anticonvulsant drug by pharmacological classification. Review of Resident #27's admission MDS assessment dated [DATE] did not indicate that Resident had a diagnosis of depression as this diagnosis was not coded under Section I (Active Diagnoses) of the MDS. Also, under Section N (Medications) of the MDS an antidepressant drug was coded as is taking and indication noted. Also, under Section N (Medications) an anticonvulsant drug was not coded as is taking and indication noted. Additionally, review of Resident #27's quarterly MDS assessment dated [DATE] did not indicate that Resident had a diagnosis of depression as this diagnosis was not coded under Section I (Active Diagnoses) of the MDS. However, Section N (Medications) of the MDS was coded as is taking and indication noted for antidepressant drug and anticonvulsant drug. On 9/17/2025 at 2:30 PM the surveyor interviewed the RN (Registered Nurse) MDS Coordinators with the Director of Nursing (DON) in attendance regarding Resident #27's inaccurate admission and quarterly MDS assessments. The surveyor reviewed the admission [DATE]) and quarterly (8/28/2025) MDS assessments with the MDS Coordinators and the DON. The surveyor conveyed that major depressive disorder was not coded in Section I (Active Diagnoses) on both MDS assessments, but Resident #27 had an active physician order for an antidepressant medication (Fluoxetine) since admission on [DATE]. Additionally, Resident had an active physician order for an anticonvulsant medication (gabapentin) since admission on [DATE] and this drug was not coded on Section N (Medications) of the admission MDS dated [DATE] but was coded on the quarterly MDS dated [DATE]. The MDS Coordinators reviewed the admission and quarterly MDS assessments for Resident #27 and acknowledged the surveyor. The MDS Coordinators stated that a modification/correction would be made to the admission MDS and the quarterly MDS assessments for Resident #27. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At the time of survey exit, no additional information was provided by the facility regarding MDS assessments.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interviews, and record review, it was determined that the facility failed to review and revise a Resident's care plan after a Resident's situation changed and a Minimum Data Set assessment was completed. This was found evident of 1 (Resident #51) out of 1 Residents reviewed for change of condition during the survey. The findings include: Care plans are developed for residents to guide the care that residents receive in the facility. They are required to be developed within 7 days of completion of a resident's admission comprehensive Minimum Data Set (MDS) assessment and revised at least every quarter (or more often as needed). The facility is required to have care plans developed and revised by an interdisciplinary team. On 9/16/25 at 10:35 AM, the surveyor reviewed Resident #51's medical record. The review revealed that Resident #51 has a Minimum Data Set (MDS) assessment with an Assessment Reference date of 7/28/25, that indicated Resident #51 had a change of condition. In the special treatments section Hospice care was not indicated. On further review a note written by Licensed Practical Nurse (LPN) #28 on 7/22/25 stated, Resident discharged today from hospice services and will continue the plan of care. Next the surveyor reviewed the Resident's active care plans. One of Resident #51's care plans was; Resident is on hospice care. On 9/17/25 at 9 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor reviewed the concern that Resident #51 had a change of condition MDS assessment where it was identified that Resident #51 no longer required hospice services and that the care plan was not updated to reflect the actual needs of the Resident. The DON confirmed that the hospice care plan should have been removed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observations and interviews it was determined that the facility failed to provide necessary adaptive equipment to a Resident based on his/her needs. This was found evident in 1 (Resident #86) of 1 resident reviewed for communication. The findings include: On 9/15/25 at 10:30 AM, the surveyor observed Resident #86 in the common dining area. Resident #86 was not wearing hearing aids and asked for questions to be repeated. On 9/15/25 at 2:16 PM, the surveyor observed Resident #86 in his/her room. The surveyor asked Resident #86 if he/she had hearing aids and Resident #86 responded that he/she did but didn't know why they didn't work. The surveyor next observed a sign on the wall that stated, Please take out his/her hearing aids each evening prior to bed and place them in the charger, make sure the light is on and they are seeded correctly. On 9/15/25 at 2:23 PM, the surveyor interviewed the Geriatric Nursing Assistant (GNA) assigned to Resident #86. GNA #6 stated that she normally did not work on the floor and had not seen any hearing aids for Resident #86. On 9/17/25 at 8:02 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #7 assigned to Resident #86. During the interview LPN #7 stated that Resident #86 had hearing aids and would have them placed after getting dressed for the morning. When asked where the hearing aids were located, LPN #7 went over to a table and opened a charging case. Inside were two hearing aids that appeared to be charged. The surveyor next reviewed Resident #86's care plan. A hearing care plan stated Resident #86 required hearing aids in both ears and require assistance to apply, remove, and/or store hearing aids. On 9/17/25 at 8:17 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the Surveyor reviewed the concerns that on 9/15/25 Resident # 86 was observed without his/her hearing aids and when the GNA was asked about the hearing aids she was not aware if the resident required them. The DON confirmed that the GNA should have known about the hearing aids through a report and the resource binder.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, staff interviews and surveyor record review, it was determined that the facility failed to follow appropriate respiratory care and services. This was found to be evident in 2 (Resident #1 and #50) out of 3 Residents reviewed for respiratory care and services. The findings include: On the initial tour of the 2nd floor nursing unit on 9/15/2025 at 10:25 AM the surveyor observed in Resident #1's room two emergency tanks of oxygen secured in carts. There was not an oxygen signage posted on the Resident #1's room door upon entry to the room. In an interview with the Licensed Practical Nurse (LPN) #20 on 9/15/2025 at 10:33 AM the surveyor asked what the expectation was for oxygen signage to be posted on the Resident room doors when oxygen tanks were in Resident rooms. LPN #20 stated that an oxygen signage should be posted on the Resident room doors when oxygen was in use and the LPN placed an oxygen signage on Resident #1's room door. At 11:00 AM on 9/16/2025 the surveyor conducted a record review of Resident #1's medical record. Review of the medical record revealed that Resident #1 had a physician order for oxygen 2Liters/minute via nasal cannula as needed (PRN) for hypoxia (absence of enough oxygen in the tissues) dated 4/2/2025. The surveyor interviewed the Director of Nursing (DON) at 8:30 AM on 9/17/2025 and asked what the expectation was for the oxygen signage to be posted on Resident room doors when oxygen tanks were in Resident rooms. The DON stated that the expectation was oxygen signage to be posted on the Resident room doors when oxygen tanks were in Resident rooms. The surveyor conveyed to the DON that two emergency oxygen tanks were observed in Resident #1's room and that there was not an oxygen signage posted on the Resident room door, and that LPN #20 was notified and placed an oxygen signage on the Resident room door. A respiratory nebulizer machine is a medical device that turns liquid medications into a fine mist, allowing the patient to inhale the fine mist directly into their lungs for respiratory conditions. It allows for direct delivery of medication to the lungs. At 4:11 PM on 9/15/2025 the surveyor observed Resident #50 in bed with oxygen in use via nasal cannula. The nasal cannula oxygen tubing was attached to the oxygen concentrator that was delivering oxygen to Resident #50's nostrils. The oxygen tubing was not labeled with date, but the oxygen humidifier bottle was labeled with date 9/12/2025. Additionally, the surveyor observed a respiratory nebulizer machine on Resident #50's bedside table. The mask to the nebulizer machine was stored in a plastic bag and labeled with date 9/12/2025, but the nebulizer tubing was not labeled with date. At 12:55 PM on 9/16/2025 the surveyor conducted a record review of Resident #50's medical record. Review of the medical record revealed that Resident #50 had physician orders for oxygen via nasal cannula every shift for SOB (shortness of breath), DuoNeb solution for nebulization inhalation for wheezing, and date and change oxygen tubing / humidification bottle weekly. The surveyor reviewed at 1:15 PM on 9/16/2025 the facility's policy for respiratory equipment dated (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/2003 and revised 1/2025. The policy indicated that the nebulizer tubing and the oxygen tubing/nasal cannula tubing would be changed every week and labeled with date of change and would be kept in a plastic bag when not in use. The surveyor observed Resident #50 again on 9/17/2025 at 7:30 AM. The oxygen tubing and nebulizer tubing were not labeled with a date. In an interview with the Director of Nursing (DON) at 8:30 AM on 9/17/2025 the surveyor asked what the expectation was for labeling/dating oxygen tubing and nebulizer tubing. The DON stated that the oxygen tubing and nebulizer tubing were to be labeled/dated and changed weekly and stored in a plastic bag when not in use. The surveyor conveyed to the DON that the oxygen tubing and the nebulizer tubing for Resident #50 was not labeled with date. At the time of survey exit, no additional information was provided by the facility regarding respiratory care.

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on medical record review and interviews it was determined that the facility failed to implement physician instructions for behaviors health needs. This was evident for 1 (Residents #51) out of 5 residents reviewed for unnecessary medications. The findings include: On 9/16/25 at 10:35 AM, the surveyor reviewed Resident #51's medical record. The review revealed that Resident #51 has a Minimum Data Set (MDS) assessment with an Assessment Reference date of 7/28/25 that indicated Resident #51 had a change of condition. In the special treatments section Hospice care was not indicated. On further review a note written by Physician #29 on 8/6/25 stated Resident #51 was recently discharged from hospice. It also stated that Resident #51's mood disorder, that was due to a medical condition, would be treated with Seroquel and Sertraline along with mental health follow up. On 9/16/25 at 12:17 PM, the surveyor interviewed Clinical Nurse Specialist Staff #21. During the interview Staff #21 stated that she had stopped seeing Resident #51 when he/she became a hospice resident. The surveyor confirmed that Staff #21 was not aware that Resident #51 was no longer receiving hospice services. On 9/16/25 at 12:49 PM, the surveyor interviewed the Director of Nursing (DON). During the interview the surveyor reviewed the concern that Resident 51's provider wrote that resident should be seen by psychiatric services however Staff # 21 was not aware that resident #51 was off of hospice services and should have been seen, The DON stated that an order should have been written to communicate that Resident #51 should have been seen by psychiatric services.