STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215255	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Grn Hlth Ctr Blakehur	1055 West Joppa Road Towson, MD 21204

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 7 (#12, #3, #7, #28, #22, #2, #4) of 23 residents reviewed during the recertification/complaint survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 12/17/25 at 10:12 AM a review of Resident #12's medical record was conducted and revealed the MDS assessment with an assessment reference date (ARD) of 11/9/25 Section M1200C, skin and ulcer/injury treatments, turning/repositioning program was checked as being performed. Review of Resident #12's medical record failed to produce documentation that the resident was on a turning and repositioning program. On 12/18/25 at 8:33 AM an interview was conducted with Staff #16 (MDS Coordinator) and the Nursing Home Administrator (NHA). Staff #16 stated that she was aware that some of the MDS assessments were coded for turning and repositioning and should not have been, that it was an error. 2) On 12/17/25 at 10:30 AM a review of Resident #3's medical record was conducted and revealed the November 2025 Medication Administration Record (MAR) that documented Resident #3 received the medication Gabapentin and Amoxicillin. Gabapentin has a drug classification of anti-convulsant but can be used to treat pain. Amoxicillin is an antibiotic to treat infection. Review of Resident #3's MDS assessment with an ARD of 11/12/25, documented in Section N, medications, that the resident was coded for no antibiotic and no anticonvulsant use. The MDS failed to capture the antibiotic and anticonvulsant. Review of Resident #3's August 2025 MAR documented the resident received Gabapentin and Levaquin (antibiotic). Review of Resident #3's MDS assessment with an ARD of 8/12/25, Section N, medications, failed to capture the anticonvulsant and antibiotic. The NHA was informed on 12/18/25 at 9:00 AM. 3) On 12/17/25 at 10:35 AM a review of Resident #7's medical record was conducted and revealed Resident #7 received bacitracin (antibiotic ointment) for a right thigh scratch on 8/27/25 to 9/2/25 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215255	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Grn Hlth Ctr Blakehur	1055 West Joppa Road Towson, MD 21204

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	per the August 2025 Treatment Administration Record (TAR). Review of Resident #7's significant change MDS assessment with an ARD of 9/2/25, section N, Medications, failed to capture the use of the antibiotic ointment. On 12/18/25 at 8:33 AM an interview was conducted with Staff #16 who confirmed the finding. 4) On 12/17/25 at 1:48 PM a review of Resident #28's medical record revealed the resident received Aspirin 81 mg. every morning. Review of Resident #28's quarterly MDS assessment with an ARD of 9/27/25, Section N, Medications, failed to capture the use of an antiplatelet, which was Aspirin, during the lookback period. Further review of the 9/27/25 MDS assessment, Section M1200C, skin and ulcer/injury treatments, turning/repositioning program was checked as being performed. Review of the medical record failed to produce documentation that the resident was on a turning and repositioning program. On 12/18/25 at 8:33 AM an interview was conducted with Staff #16 and the NHA. Staff #16 stated that she was aware that some of the MDS assessments were coded for turning and repositioning and should not have been, that it was an error. 5) Review of Resident #22's medical record on 12/16/25 revealed a MDS assessment with an assessment reference date (ARD) of 10/19/25 in Section P0100 Physical Restraints was coded for A. Bed rail. The MDS definition for Physical restraints is any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Observation of Resident #22 on 12/16/25 at 9:13 AM and 11:22 AM revealed no bed rails in use and no restraints in place to restrict the Resident's movements. Interview on 12/18/25 at 8:30 AM with Staff #16 (MDS Coordinator) confirmed Resident #22 should not have been coded for restraints on 10/19/25 MDS Section P0100. Interview on 12/18/25 at 8:40 AM with the Administrator confirmed the Surveyor's findings. 6) Review of Resident #2's medical record on 12/15/25 revealed a MDS assessment with an assessment reference date (ARD) of 10/14/25 in Section P0100 Physical Restraints was coded for A. Bed rail. The MDS definition for Physical restraints is any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Observation of Resident #2 on 12/15/25 at 12:39 PM and on 12/16/25 at 11:20 AM revealed the Resident was in a recliner next to the Resident's bed. At those times no bed rails were noted in use and no restraints in place to restrict the Resident's movements. Interview on 12/18/25 at 8:30 AM with Staff #16 (MDS Coordinator) confirmed Resident #2 should not have been coded for restraints on 10/14/25 MDS Section P0100. Interview on 12/18/25 at 8:40 AM with the Administrator confirmed the Surveyor's findings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215255	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Grn Hlth Ctr Blakehur	1055 West Joppa Road Towson, MD 21204

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7) Review of Resident #4's medical record on 12/15/25 revealed a MDS assessment with an assessment reference date (ARD) of 11/5/25 in Section P0100 Physical Restraints was coded for A. Bed rail. The MDS definition for Physical restraints is any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Observation of Resident #4 on 12/15/25 at 2:04 PM and on 12/16/25 at 11:21 AM revealed the Resident was in a wheelchair next to the Resident's bed. At those times no bed rails were noted in use and no restraints in place to restrict the Resident's movements. Interview on 12/18/25 at 8:30 AM with Staff #16 (MDS Coordinator) confirmed Resident #4 should not have been coded for restraints on 11/5/25 MDS Section P0100. Interview on 12/18/25 at 8:40 AM with the Administrator confirmed the Surveyor's findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215255	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Grn Hlth Ctr Blakehur	1055 West Joppa Road Towson, MD 21204

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and review of facility policies and procedures, it was determined the facility failed to 1) timely respond to concerns noted on pharmacy reviews and, 2) have policies and procedures in place for monthly drug regimen review to include time frames for the different steps in the process. This was evident for 5 (#4, #6, #26, #28, #7) of 6 residents reviewed for monthly drug regimen review during a recertification/complaint survey.The findings include: 1) Review of Resident #4's medical record on 12/16/25 revealed the Resident was admitted to the facility on [DATE]. Further review of Resident #4's medical record the Pharmacist conducted a MRR (Monthly Regimen Review) on 11/13/25 and documented Irregularities (see consultant pharmacist report). Further review of Resident #4's medical record revealed no consultant pharmacist report from 11/13/25. On 12/17/25 at 10:42 AM the Director of Nursing (DON) was asked about the MRR for November, and she stated they were in her office. Review of Resident #4's pharmacist MRR Note to Physician/Prescriber dated 11/13/25 revealed it stated Lidocaine patches should only be applied once daily with 12 hour on and 12 hour off period. Please clarify directions. There was no documented response from the Physician/Prescriber. Review of Resident #4's physician orders on 12/17/25 revealed the Pharmacist's 11/13/25 recommendations had still not been addressed. Interview with the Director of Nursing on 12/17/25 at 2:15 PM confirmed Resident #4's November MMR was not addressed by the physician/prescriber and was not in Resident #4's medical record. 2) Review of Resident #6's medical record on 12/16/25 revealed the Resident was admitted to the facility in 2024. Further review of Resident #6's medical record the Pharmacist conducted a MRR (Monthly Regimen Review) on 11/13/25 and documented Irregularities (see consultant pharmacist report). Further review of Resident #6's medical record revealed no consultant pharmacist report from 11/13/25. On 12/17/25 at 10:42 AM the Director of Nursing (DON) was asked about the MRR for November, and she stated they were in her office. Review of Resident #6's pharmacist MRR Note to Physician/Prescriber dated 11/13/25 revealed there was no documented response from the Physician/Prescriber. Interview with the Director of Nursing on 12/17/25 at 2:15 PM confirmed Resident 6's November MMR was not addressed by the physician/prescriber and was not in Resident #6's medical record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215255	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Grn Hlth Ctr Blakehur	1055 West Joppa Road Towson, MD 21204

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Review of Resident #26's medical record on 12/16/25 revealed the Resident was admitted to the facility in 2024. Further review of Resident #26's medical record the Pharmacist conducted a MRR (Monthly Regimen Review) on 8/11/25 and 11/13/25 and documented Irregularities (see consultant pharmacist report). Further review of Resident #26's medical record revealed no consultant pharmacist report from 8/11/25 and 11/13/25. On 12/17/25 at 10:42 AM the Director of Nursing (DON) was asked about the MRR for August and November, and she stated they were in her office. Review of Resident #26's pharmacist MRR Note to Physician/Prescriber dated 8/11/25 and 11/13/25 revealed there was no documented response from the Physician/Prescriber. Interview with the Director of Nursing on 12/17/25 at 2:15 PM confirmed Resident 26's August and November MMR were not in Resident #26's medical record. 4) On 12/17/25 at 10:05 AM a review of Resident #28's medical record revealed on 11/13/25 the Pharmacist conducted a Monthly Regimen Review (MRR) and documented Irregularities (see consultant pharmacist report). Further review of Resident #28's medical record revealed no consultant pharmacist report from 11/13/25. On 12/17/25 at 10:42 AM the Director of Nursing (DON) was asked about the MRR for November, and she stated they were in her office. The DON provided the 11/13/25 recommendation for Resident #28 that stated, Aspirin 81 mg. is not recommended for osteoarthritis as it is not an effective dose for pain. Please clarify diagnosis. The recommendation was not acted upon or reviewed by the physician as evidenced by a blank physician response as of 12/17/25. 5) On 12/17/25 at 10:10 AM a review of Resident #7's medical record revealed on 11/13/25 and 10/28/25 the Pharmacist conducted a Monthly Regimen Review (MRR) and documented Irregularities (see consultant pharmacist report). Further review of Resident #7's medical record revealed no consultant pharmacist reports from 11/13/25 and 10/28/25. On 12/17/25 at 10:42 AM the DON stated the MRRs were in her office. The DON provided the reviews for 11/13/25. Review of the recommendation for 11/13/25: Bumetanide oral tablet 2 mg: give 2 mg. by mouth one time a day for edema hold for SBP (systolic blood pressure) less than 100. Please update MAR (Medication Administration Record) to include BP measurements so nursing knows when to hold bumetanide order when indicated per hold parameter. The recommendation was not reviewed or acted upon. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215255	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Grn Hlth Ctr Blakehur	1055 West Joppa Road Towson, MD 21204

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the recommendation for 11/13/25: Metoprolol Succinate ER oral tablet extended releases 24-hour 25 mg; give 25 mg by mouth 2 times a day for HTN, hold for SBP less than 110, heart rate less than 60. Metoprolol succinate is recommended to be administered once daily. Metoprolol tartrate can be administered twice daily. Please consider decreasing frequency of metoprolol succinate order to once daily or changing to metoprolol tartrate. The recommendation was not reviewed by the physician. On 12/17/25 at 12:25 PM a review of the Medication Regimen Reviews (MRR) Policy that was given to the surveyor by the Nursing Home Administrator (NHA) documented the following: Timeframe for reporting: #1. Within 24 hours of the MRR, the consultant pharmacist provides a written report to the attending physicians for each resident identified as having a medication irregularity that is deemed not life threatening. #2. If the identified irregularity represents a risk to a person's life, health, or safety, the consultant pharmacist contacts the physician immediately (within one hour) to report the information to the physician verbally and documents the notification. #3. The consultant pharmacist provides the director of nursing services and medical director with a written, signed and dated copy of all medication regimen reports. #4. Copies of all medication regimen review reports, including physician responses, are maintained as part of the permanent medical record. Physician response: #1: upon receiving the MRR report from the pharmacist, the attending physician reviews and responds to the report. The physician documents in the resident's medical record that the pharmacist's recommendations have been reviewed and what (if any) actions were taken to address them. #2. If the physician does not provide a timely or adequate response, or the consultant pharmacist identifies that no action has been taken he/she contacts the medical director of (if the medical director is the physician of record) the administrator. There was no timeframe in the policy that stated within what timeframe the physician was notified and how long it would take from the time of notification to correct the concern and respond back. On 12/17/25 at 2:27 PM the DON confirmed the consultant pharmacist reports for Residents #28 and Resident #7 were not in the residents' medical records. At that time the DON was asked about the process for pharmacy reviews. The DON stated the monthly reviews were done and she would receive the reports from the pharmacist. The DON would then give the recommendations to the Nurse Practitioner (NP) and either they would either agree or disagree with the recommendation. The DON stated she would send back copies to the pharmacist when complete. The DON stated she kept the recommendations in a binder in her office and not in the resident's medical record. The Nursing Home Administrator was informed of the concern on 12/18/25 at 12:00 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215255	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Grn Hlth Ctr Blakehur	1055 West Joppa Road Towson, MD 21204

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on medical record review and interview, it was determined that the facility failed to document residents were offered and provided education regarding the benefits, risks, and potential side effects of receiving the influenza and pneumococcal vaccines to residents; and failed to maintain documentation related to influenza and pneumococcal vaccination in residents' medical records. This was evident for 2 of 5 residents (Resident #4, #5) reviewed for influenza vaccination and 4 of 5 residents (Resident #1, #4, #5, #36) reviewed for pneumococcal vaccinations during a recertification/complaint survey. The findings include: 1.Review of Resident #1's medical record on 12/16/25 for influenza and pneumococcal vaccinations revealed no documentation of the Resident's pneumococcal vaccination status. After Surveyor intervention, the facility staff obtained Resident's #1 pneumococcal vaccination documentation on 12/17/25 from ImmuNet. ImmuNet is a confidential database that stores immunization records and makes them available to health care providers. 2. Review of Resident #4's medical record on 12/16/25 for influenza and pneumococcal vaccinations revealed no documentation the Resident was offered influenza vaccination in 2025 and no record of the Resident's pneumococcal vaccination.After Surveyor intervention, the facility staff obtained Resident #4's influenza and pneumococcal vaccination documentation from the Resident's Assisted Living on 12/17/25.3. Review of Resident #5's medical record on 12/16/25 for influenza and pneumococcal vaccinations revealed no documentation the Resident was offered influenza vaccination in 2025 and no record of the Resident's pneumococcal vaccination.Interview with the Director of Nursing on 12/17/25 at 10:42 AM stated the Resident's representative has declined vaccinations for Resident #5 for years. Interview with the Director of Nursing on 12/18/25 at 10:28 AM confirmed the facility staff failed to document they offered and the Resident's representative declined influenza and pneumococcal vaccinations for 2025 in the Resident's medical record.4.Review of Resident #36's medical record on 12/16/25 for influenza and pneumococcal vaccinations revealed no documentation the Resident's pneumococcal vaccination status.Interview with the Director of Nursing on 12/17/25 at 10:30 AM confirmed Resident #36's pneumococcal vaccination status is not documented in the Resident's medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215255	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Grn Hlth Ctr Blakehur	1055 West Joppa Road Towson, MD 21204

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, it was determined that facility staff failed to treat residents with dignity. This was evident for 1 (Resident #12) of 6 residents observed during the recertification/complaint survey. The findings include:On 12/17/25 at 12:48 PM observation was made of Geriatric Nursing Assistant (GNA) #5 sitting in a chair next to Resident #12 on the left side of the bed. Prior to the surveyor knocking on the door to Resident #12's room, the surveyor observed, by the reflection in the glass of a picture on the right side of the wall (entrance), of GNA #5 sitting next to the resident. At the time of the observation, GNA #5 was looking down and not feeding Resident #12. The survey knocked on the door and entered and saw GNA #5 give a spoonful of pureed food. The surveyor observed a cell phone lying next to Resident #12 on the bed that was opened with a text message thread. On 12/17/25 at 2:30 PM the cell phone policy was reviewed after being received from the Nursing Home Administrator (NHA). The policy stated, to ensure residents are provided uninterrupted quality service, staff members are not permitted to use wireless communication devices (i.e. mobile phone, pagers, electronic listening devices, iPod, computer games, televisions, etc.) during scheduled work hours and/or in work areas. On 12/17/25 at 2:35 PM the NHA and the Director of Nursing (DON) were informed of the observation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215255	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Grn Hlth Ctr Blakehur	1055 West Joppa Road Towson, MD 21204

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on interview, observation, and medical record review, it was determined the facility failed to ensure that the resident's call light was within reach, per the individualized care plans, to allow access to assistance when needed by staff. This was evident for 1 (Resident #7) of 12 residents interviewed during the recertification/complaint survey. The findings include: On 12/15/25 at 10:51 AM, while interviewing Resident #7, Resident #7 stated that he/she could not reach the call bell that was lying on the bed. Resident #7 was sitting in a reclining chair with his/her walker next to him/her on the right side. Resident #7's legs were reclined. The surveyor asked Resident #7 how he/she called the nurse and the response was, I just yell out for them. The surveyor went to get the nurse, Staff #4 who stated that Resident #7 normally had someone help him/her get out of bed into the chair. Staff #5 stated that the resident typically was gotten out of bed by the geriatric nursing assistant but at times would get out of bed without waiting for assistance. At that time, Staff #4 placed the call bell next to the resident. Review of Resident #7's care plan, at risk for falls had the intervention, place call system and most frequently used items within resident reach.On 12/17/25 at 2:27 PM the Director of Nursing was informed of the observation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215255	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Grn Hlth Ctr Blakehur	1055 West Joppa Road Towson, MD 21204

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on review of facility documentation and interview, it was determined that the facility failed to ensure a registered nurse was on duty of at least 8 consecutive hours 7 days a week. This was found to be evident for 2 of 14 days reviewed during a recertification/complaint survey. The findings include: A review was conducted on 12/16/25 of the daily staffing sheets from 12/1-12/14/25 provided by the Administrator. The review revealed there were 2 days (12/6 and 12/7/25) with no RN coverage for day, evening and night shifts. Interview with the Administrator on 12/17/25 at 3:02 PM confirmed there was no RN on duty for 12/6 and 12/7/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215255	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Grn Hlth Ctr Blakehur	1055 West Joppa Road Towson, MD 21204

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on medical record review and interview, it was determined the facility staff failed to ensure a resident's drug regimen was free from unnecessary drugs (Resident #7 and #36). This was evident for 2 of 6 residents reviewed during the recertification/complaint survey. The findings include: 1) The facility staff failed to monitor the blood pressure and heart rate prior to administering a blood pressure medication with physician ordered parameters. On 12/17/25 at 10:05 AM Resident #7's medical record was reviewed and revealed a physician's order for Metoprolol Succinate ER 25 mg. to be given twice per day and to hold for the SBP (systolic blood pressure) if below 110 and heart rate less than 60. Systolic blood pressure is the top number of a blood pressure reading. Metoprolol is used to treat high blood pressure, chest pain, and heart failure. Review of Resident #7's September 2025, October 2025, November 2025, and December 2025 Medication Administration Records (MAR) revealed the Metoprolol was given every morning at 9:00 AM and every evening at 5:00 PM. When the medication was administered it was indicated by nurses initialing and checking off that the medication was given. There was no place on the MAR where the blood pressure and heart rate was documented as being done and monitored prior to the administration of the medication. Review of the vital sign section of Resident #7's medical record from September 2025 to December 2025 was inconsistent as to the days and times the vital signs were taken, and the vital signs were not taken every day and in the evening to correlate when the medication was administered. The finding of the vital signs not being monitored prior to the administration of the Metoprolol was corroborated by the monthly medication record reviews (MRR) by the pharmacist. Cross Reference F756 On 12/17/25 at 2:27 PM the concern was discussed with the Director of Nursing who confirmed the finding, and she stated they had some education to do. 2) The facility staff failed to do a gradual dose reduction for Resident #36 who is taking a psychotropic medication. Medical record review on 12/17/25 revealed on 2/10/20 Resident #36 was admitted to this facility. Resident #36 has a history of depression, falls, speech disturbance, Vascular dementia, asthma, pain the both shoulders from osteoarthritis and has been resistive to care in the past. On 6/7/24 Resident #36 entered into hospice care at the facility. Since the Resident was on hospice care, the Resident no longer received psychiatric services. The Resident was ordered and was still taking quetiapine 12.5 mg every night for vascular dementia. There was no gradual dose reduction done and nursing had not recorded any side effects of medications or any behaviors Resident #36 had, to determine if the Resident continued to need the medication. An interview with geriatric nursing assistant staff # 12 stated that when the Resident was first admitted here he/she was resisting care all the time, however now she/he is very cooperative with care. On 12/16/25 staff # 17 also stated that The Resident has been cooperative with care and does not resist care like he/she used to. Administrator and Director of Nursing are aware.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215255	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Grn Hlth Ctr Blakehur	1055 West Joppa Road Towson, MD 21204

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined that the facility staff failed to obtain laboratory tests as ordered by the nurse practitioner for a resident (Resident #4). This was evident for 1 of 23 residents reviewed during a recertification/complaint survey.The findings include:Review of Resident #4's medical record on 12/16/25 revealed the Resident was admitted to the facility on [DATE] following a hospitalization that included an orthopedic surgery.Further review of Resident #4's medical record revealed the Resident was seen by the Nurse Practitioner (Staff #18) on 11/11/25. At that time Staff #18 documented Will follow-up lab work on Thursday including Vitamin D level.Review of Resident #4's paper medical record revealed on 11/11/25 Staff #18 ordered a CBC (Complete Blood Count), CMP (Comprehensive Metabolic Panel) and Vitamin D level.Further review of Resident #4's medical record revealed the Resident did not have the laboratory tests as ordered.Interview with Administrator on 12/17/25 at 10:45 AM confirmed the facility staff failed to obtain laboratory tests as ordered by the nurse practitioner on 11/11/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215255	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Grn Hlth Ctr Blakehur	1055 West Joppa Road Towson, MD 21204

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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, it was determined the facility staff failed to obtain timely radiology services for residents. This was evident for 1 (Resident #7) of 12 residents interviewed during a recertification/complaint survey.The findings include: On 12/15/25 at 10:55 AM an interview was conducted with Resident #7. Resident #7 stated that he/she was having difficulty lifting their left leg. Resident #7 stated, I can walk but just can't lift it. On 12/16/25 at 11:32 AM a review of Resident #7's medical record was conducted and revealed a 12/11/25 nursing note that documented the resident was evaluated by the Hospice nurse secondary to a call that was received from the facility day shift nurse assigned to the resident on 12/10/25 that documented, patient is unable to lift or move leg and previously was able. The note continued x-ray approved by Hospice. X-ray order placed with [name] at 3:30 pm. A 12/12/25 at 9:00 AM nurse practitioner note documented, x-ray of the left hip was ordered and currently pending. The note ended, will follow up on x-ray results. A 12/13/25 at 6:41 AM nursing note documented, resident was having left hip and leg pain. An x-ray was ordered several days ago. Several calls made to [name]. Sent an ETA of between 8 and 10:30 pm today for x-ray to be done. A 12/14/25 at 20:36 (8:36 PM) nursing note documented, [name] arrived at 11:45 am to perform scheduled x-ray of L hip and L fibula/tibula. X-ray is rescheduled for tomorrow morning due to resident not available today. A 12/15/25 at 19:24 (7:24 PM) note documented the x-ray was done, which was 4 days after ordered. On 12/16/25 at 12:10 PM an interview was conducted with the Director of Nursing (DON) who stated that the order should have been put in the computer first and then the x-ray company should have been called to schedule the x-ray. On 12/16/25 at 1:45 PM the DON and NHA (nursing home administrator) informed the surveyor that the x-ray request was called in and then put into the computer system later. The DON and NHA stated they did not know why it took the x-ray company so long to come to the facility. The NHA agreed that there should have been communication to the resident prior to the resident going out on 12/14/25, that the x-ray company would be coming to perform the x-ray that morning.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215255	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Grn Hlth Ctr Blakehur	1055 West Joppa Road Towson, MD 21204

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 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interviews, the facility failed to schedule a surgical follow-up appointment for a resident (Resident #4). This was evident for 1 of 23 residents reviewed during a recertification/complaint survey.The findings include:Review of Resident #4's medical record on 12/16/25 revealed the Resident was admitted to the facility on [DATE] following a hospitalization that included an orthopedic surgery.Review of Resident #4's hospital discharge instructions revealed it stated Follow-up: Surgeon in 6 weeks, or upon discharge from the rehab facility.During interview with Resident #4 on 12/17/25 at 8:59 AM, the Resident stated he/she does not have a follow-up appointment scheduled with the surgeon.Interview with the Scheduler (Staff #10) on 12/17/25 at 9:14 AM and review of the scheduling book for residents at that time, confirmed there is no follow-up appointment scheduled for Resident #4.Interview with the Administrator on 12/17/25 at 9:20 AM confirmed Resident #4 has been at the facility for 7 weeks; the Resident does not have an anticipated discharge date and there is no follow-up surgical appointment scheduled for Resident #4.After Surveyor intervention, a follow up surgical appointment was scheduled for the Resident on 1/5/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215255	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Grn Hlth Ctr Blakehur	1055 West Joppa Road Towson, MD 21204

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of employee health records and resident medical records; and staff interview, it was determined the facility failed to document residents and staff were offered and provided education regarding the benefits, risks, and potential side effects of receiving the COVID-19 vaccine to residents; and failed to maintain documentation related to COVID-19 vaccination in residents and staff records. This was evident for 3 of 5 residents (Resident #1, #4, #5) and 1 of 5 staff (Employee #21) reviewed during a recertification/complaint survey. The findings include: A COVID-19 vaccine is intended to provide acquired immunity against severe acute respiratory syndrome coronavirus 2, the virus that causes coronavirus disease. 1)The facility staff failed to maintain COVID-19 vaccination records for all residents. A)Review of Resident #1's medical record on 12/17/25 revealed the Resident was admitted to the facility on [DATE]. Further review of Resident #1's medical record revealed no documentation the Resident was offered and provided education on the COVID-19 vaccination; received or declined the COVID-19 vaccination since admission. B) Review of Resident #4's medical record on 12/17/25 revealed the Resident was admitted to the facility on [DATE]. Further review of Resident #4's medical record revealed no documentation the Resident was offered and provided education on the COVID-19 vaccination; received or declined the COVID-19 vaccination since admission. C) Review of Resident #5's medical record on 12/17/25 revealed the Resident was admitted to the facility in 2023. Further review of Resident #5's medical record revealed no documentation the Resident was offered and provided education on the COVID-19 vaccination; received or declined the COVID-19 vaccination in 2025. Interview with the Director of Nursing on 12/17/25 at 10:30 AM confirmed the Surveyor's findings for Residents #1, #4 and #5. 2)The facility staff failed to maintain COVID-19 vaccination records for all employees. Review of Employee #21 health record on 12/18/25 revealed Employee #21 was hired on 4/14/25. Further review of Employee #21 health record on 12/18/25 revealed no documentation the Employee was offered and provided education on the COVID-19 vaccination; received or declined the COVID-19 vaccination since hired. Interview with the Administrator on 12/18/25 at 11:30 AM confirmed the Surveyor's findings.