

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/31/2025
NAME OF PROVIDER OR SUPPLIER  Pickersgill Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE  615 Chestnut Avenue 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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50573</p> <p>Based on observation and interview, it was determined that the facility failed to ensure residents were treated with dignity and respect. This was evident during observation of 19 rooms on 1 unit (Decker Unit) during the survey.</p> <p>The findings include:</p> <p>On 01/29/25 at 08:16 AM, the initial observation of the facility revealed rooms 406, 413, 416, 418, 419, 420, 421, 422, 424, 425, 426, 427, 428, 429, 430, 431, 432, 434, 435, which had over-the-door organizers on the outside of the doors. The organizers contained various resident care items, including briefs.</p> <p>On 01/31/25 at 08:15 AM, an interview with Resident #28, who resided in room [ROOM NUMBER], revealed that he/she did not know why the organizers were on the outside of the resident room door and was unhappy about it due to a privacy concern.</p> <p>On 01/31/25 at 2:05 PM, at the time of exit, the surveyor reviewed the concern regarding the failure to ensure residents are treated with dignity and respect.</p>		

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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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>50573</p> <p>Based on observation and interview, it was determined that the facility failed to ensure a resident's medical record was protected from public view. This was evident for 1 of 2 medication carts (400 hallway medication cart) observed during the survey.</p> <p>The findings include:</p> <p>On 01/30/25 at 07:57 AM, an observation on the Decker Unit revealed a medication cart on the 400 hallway which revealed a computer screen open with Resident #21's name, date of birth, and Medication Administration Record (MAR). The same medication cart which the computer was on was unlocked, which would allow anyone to open medication cart drawers with several resident medications inside.</p> <p>On 01/30/25 at 08:00 AM, an observation revealed Registered Nurse Supervisor (RN #22) walked up to the medication cart and closed out of the screen which was revealing Resident #21's information and locked the cart. The surveyor approached RN #22 and asked if she was assigned to the medication cart at the time, she indicated yes.</p> <p>On 01/30/25 at 8:00 AM, an interview with RN #22 revealed that the expectation was for nurses to close out of computer screens which reveal resident information and to lock the medication cart whenever they walked away from it. She further indicated that she was pulled away for a resident need and did not lock the cart or close out of the resident revealing computer screen.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>50457</p> <p>Based on record reviews and interviews, it was determined that facility staff failed to update the residents' (#8) Minimum Data Set to accurately reflect the resident's medical condition, and failed to code the residents' (#16, #31) status accurately on the Minimum Data Set (MDS) assessment. This occurred for 3 (#8, #16, #31) out of 3 residents reviewed during the annual survey.</p> <p>The findings include:</p> <p>The Minimum Data Set (MDS) is a federally mandated assessment tool that helps nursing home staff gather information on each resident's strengths and needs. The information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. The Assessment Reference Date (ARD) is the specific end point of look-back periods of resident status for the MDS assessment process.</p> <p>1) On 01/31/25 at 7:38 AM, a review of Resident #8's treatment administration record for December 2024 revealed an order to apply Optifoam (foam wound dressing) pad to sacrum topically every day. The treatment order start date was 12/03/2024 at 7:00 AM, and discontinue date was 01/30/2025 5:20PM.</p> <p>On 01/31/25 at 9:07 AM, the surveyor reviewed a wound evaluation note dated 12/31/24 for Resident #8. The evaluation indicated an MDS 3.0 stage 3 wound, and the provider noted wound progress. Review of Resident #8's MDS under the skin condition section on 01/31/25 at 8:42 AM, failed to indicate an unhealed stage 3 pressure ulcer. The assessment reference date (MDS completion) was 01/15/25.</p> <p>On 01/31/25 at 10:10 AM, during an interview with MDS coordinator #14, when asked why a stage 3 pressure ulcer was not captured in the MDS by the ARD of 01/15/25. The MDS coordinator #14 explained that updates to the MDS are based on staff documentation and that Resident #8's pressure ulcer had been documented as healed. The surveyor requested documentation confirming that the pressure ulcer was recorded as healed.</p> <p>On 01/31/25 at 11:14 AM, during an interview with Nurse Unit Manager (UM) #5 the surveyor inquired about the status of Resident#8's pressure ulcer. The UM #5 explained that the wound initially started as a stage 2 pressure ulcer, progressed to stage 3, and was currently healing. The surveyor asked if the pressure ulcer was fully healed, the UM #5 responded, It isn't healed.</p> <p>On 01/31/25 at 11:32 AM, review of wound care progress note dated on 01/14/25 by the physician revealed, Signing off on patient who remains in the facility. Per nursing, the wound continues to heal. Please reconsult if the wound worsens.</p> <p>On 01/31/25 at 12:11 PM, the Director of Nursing (DON) #2 provided the surveyor with a copy of an amended MDS reflecting a correction was made on 01/31/25 in the skin condition section to indicate a pressure ulcer. The DON #2 acknowledged that the pressure ulcer had not been documented in the MDS by the ARD of 01/15/25.</p> <p>50573</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2) On 01/30/25 at 10:21 AM, review of Resident #16's medical record revealed a progress note dated 12/03/25 at 4:40 PM, which indicated the resident had been seen by the wound doctor that day for a left first toe wound.</p> <p>On 01/30/25 at 10:24 AM, review of Resident #16's medical record revealed an assessment titled, Wound Evaluation and Management Summary, dated 12/3/24 which indicated the resident had a wound on his/her left first toe.</p> <p>On 01/30/25 at 10:27 AM, review of section M (skin conditions) of Resident #16's most recent MDS with an ARD of 12/6/24 failed to reveal indication that the resident had a pressure ulcer injury.</p> <p>On 01/31/25 at 10:10 AM, an interview with the Director of Nursing (DON, Staff #2) revealed that Resident #16's toe injury was a pressure ulcer and should have been coded on the MDS with an ARD date of 12/6/24.</p> <p>3) On 01/29/25 at 08:14 AM, an initial observation of Resident #31 revealed that he/she had an air mattress. An air mattress can eliminate pressure sores and ulcers from forming and existing sores from worsening.</p> <p>On 01/30/25 at 02:33 PM, review of Resident #31's medical record revealed a progress note dated 1/9/25 at 03:14 AM, which indicated that the resident's wound dressing was intact and right heel dressing applied.</p> <p>On 01/30/25 at 02:34 PM, further review of Resident #31's medical record revealed a progress note dated 1/11/25 at 03:32 AM, which indicated there was a new cream medication ordered for multiple skin issues on trunk and arms.</p> <p>On 01/30/25 at 02:36 PM, further review of Resident #31's medical record revealed an assessment titled, Wound Evaluation and Management Summary dated 1/7/25 which indicated the resident had wounds on his/her right lower leg, right upper calf, and right heel.</p> <p>On 01/30/25 at 02:27 PM, an interview with the MDS Coordinator (Staff #14) revealed that staff rely on progress notes and wound assessments to complete section M of the MDS.</p> <p>On 01/30/25 at 02:37 PM, review of section M (skin conditions) of Resident #31's recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/13/25 failed to reveal any indication that the resident had any wounds or skin conditions.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>50573</p> <p>Based on record review and staff interview, the facility failed to ensure a resident received care based on professional standards. This was evident for 1 (Resident #16) of 2 residents reviewed for skin conditions.</p> <p>The findings include:</p> <p>On 01/29/25 at 08:18 AM, an initial observation of Resident #16 revealed a small bruise-like area on the his/her left clavicle.</p> <p>On 01/30/25 at 10:21 AM, review of Resident #16's medical record failed to reveal documentation indicating the skin condition was identified.</p> <p>On 01/30/25 12:17 PM, an interview with the Quality Assurance Nurse (Staff #20) revealed that she was assigned to Resident #16. She indicated she was not aware of Resident #16's current skin conditions. The surveyor and Staff #20 walked to the residents room and the surveyor pointed out the area of concern on his/her left clavicle. Staff #20 said that the resident has ecchymosis.</p> <p>On 01/30/25 at 12:20 PM, the surveyor requested documentation of Resident #16's weekly skin checks from Staff #20.</p> <p>On 01/30/25 at 12:27 PM, an interview with the Unit Manager (Staff #5) revealed that the facility switched over from paper to online weekly skin checks between November and December of 2024, that they had missed Resident #16's weekly skin checks since, and have none since to provide.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50573</b></p> <p>Based on observation and interview with facility staff, it was determined that the facility failed to ensure that a resident receiving oxygen therapy had orders that were being followed and failed to post cautionary signs indicating the use of oxygen. This was evident for 1 (Resident #31) of 1 resident reviewed for respiratory care, and 1 (Resident #9 and #31) of 2 residents observed receiving oxygen.</p> <p>The findings include:</p> <p>1) On 01/29/25 at 08:14 AM, an initial observation of Resident #31 revealed she/he was on oxygen by nasal cannula. The oxygen level was at 3.5 liters/minute. The nasal cannula was dated 1/27/25.</p> <p>A nasal cannula is a small, flexible tube that fits inside both nostrils, delivering supplemental oxygen directly into your nose. Oxygen liter refers to the amount of oxygen a person receives per minute, measured in liters, and is essentially how much supplemental oxygen is being delivered to them through a piece of oxygen supplying equipment.</p> <p>On 01/29/25 at 02:33 PM, review of Resident #31's medical record revealed an active order dated 1/6/25 which indicated continuous oxygen at 3 liters by nasal cannula.</p> <p>On 01/29/25 at 02:33 PM, further review of Resident #31's medical record revealed an active order dated 1/6/25 which indicated to change the oxygen tubing/nasal cannula tubing every Thursday night shift and to label with the date.</p> <p>On 01/30/25 at 07:12 AM, a second observation of Resident #31 revealed he/she was still on oxygen by nasal cannula, at a rate of 3.5- 4 liters/minute. The nasal cannula was dated 1/17/25.</p> <p>On 01/30/25 at 07:25 AM, an interview with the Director of Nursing (DON, Staff #2) revealed the expectation for residents on oxygen is for the orders to be followed by staff and if the level of oxygen needs to be increased or decreased, that staff should reach out to the provider.</p> <p>On 01/30/25 at 07:28 AM, the surveyor and the DON went to Resident #31's room. The DON read the oxygen level on Resident #31's oxygen supplying equipment and indicated it was at 4 liters/minute. The surveyor also reviewed the concern regarding the tubing dated 1/17/25.</p> <p>2a) On 01/30/25 at 07:28 AM, an observation with the DON of Resident #31 in his/her room revealed he/she was on oxygen. When the surveyor asked what the expectation was for signage when a resident is on oxygen, she indicated that there would be a red oxygen sign on the resident's door. She indicated that there failed to be one on Resident #31's door, and that she would go and get one.</p> <p>2b) On 01/30/25 at 12:18 PM, an observation on Decker Unit revealed Resident #9, in room [ROOM NUMBER], who was actively receiving oxygen by nasal cannula, but failed to reveal a sign on the resident's door indicating the use of oxygen.</p> <p>(continued on next page)</p>		

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F 0695  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	On 01/31/25 at 10:10 AM, the surveyor reviewed the concern with the DON regarding the failure to ensure cautionary signage was posted for Resident #9 and #31.		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>50573</p> <p>Based on observation, record review and interview with facility staff, it was determined that the facility failed to obtain informed consent and document alternatives attempted prior to the initiation of bed rails. This was evident for 2 (Resident #31 and #13) of 2 residents reviewed for accident hazards.</p> <p>The findings include:</p> <p>Bedrails or side rails are adjustable bars that attach to the bed. They vary in size, including full, half, and quarter lengths depending on their intended purpose. They can be used to prevent falls, help assist residents with movement, and provide a feeling of security. Bed rails also have potential risks associated with them. The facility should obtain a signed consent form before the use of bedrails.</p> <p>1) On 01/29/25 at 08:14 AM, during the initial phase of the survey, the surveyor observed Resident #31 in bed with two 1/4 bed rails up on either side of the top end of the bed.</p> <p>On 01/30/25 at 09:37 AM, an interview with the Director of Rehabilitation (Staff #16), revealed that Resident #31 was from assisted living and had not been on case load and was unable to indicate why the resident had the transfer bars/bed rails.</p> <p>2) On 01/29/25 at 10:05 AM, during the initial phase of the survey, the surveyor observed Resident #13's bed in his/her room which revealed two 1/4 bed rails up on either side of the top end of the bed.</p> <p>On 01/30/25 at 07:23 AM, an interview with the Director of Nursing (DON, Staff #2) revealed that verbal consent is obtained for transfer bars/ bed rails, but would double check for documentation.</p> <p>On 01/30/25 at 09:37 AM, an interview with the Director of Rehabilitation (Staff #16), revealed that therapy will assess resident ability and determine whether transfer bars are necessary. The surveyor requested documentation for Resident #13 and #31 of alternatives attempted and the initial assessments completed for the transfer bars/ bed rails.</p> <p>On 01/30/25 at 11:09 AM, the DON indicated to the surveyor that she was unable to provide documentation of alternatives attempted and consent for Resident #13 and #31's prior to initiation of transfer bars/bed rails.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>50573</p> <p>Based on interview, it was determined that the facility failed to ensure staff received annual performance reviews. This was evident for 4 of 5 GNAs (GNA#7, GNA #19, GNA #21, and GNA #26) reviewed during the annual survey.</p> <p>The findings include:</p> <p>On 01/30/24 at 4:00 PM, the surveyor requested documentation of annual performance reviews for the last two years (2023 and 2024) for GNA #7, GNA #19, GNA #21, and GNA #26.</p> <p>On 01/31/25 at 10:10 AM, an interview with the Director of Nursing (DON) revealed that the facility was unable to provide the documentation requested by the surveyor because the facility was not in compliance with annual performance reviews for GNA #7, GNA #19, GNA #21, and GNA #26.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>50573</p> <p>Based on observation, record review, and interview, it was determined that the facility failed to have a medication error rate of less than 5% during medication administration observation. This was evident for 3 (Resident #9, #16, and #236) of 26 medication administration opportunities which resulted in a medication error rate of 11.54%.</p> <p>The findings include:</p> <p>1) On 01/30/25 at 08:02 AM, the surveyor observed Registered Nurse (RN) Supervisor #22 administer 4 medications to Resident #236.</p> <p>On 01/30/25 at 08:15 AM, the surveyor observed RN #22 document the medications, which revealed 5 medications being signed off as administered, which included Bicalutamide 50MG, which was not observed to be prepared or administered to Resident #236.</p> <p>On 01/30/25 at 08:26 AM, review of Resident #236 Medication Administration Record (MAR) revealed 5 medications signed off, including Bicalutamide Tablet 50 MG (A drug used with another drug to treat prostate cancer that has spread to other parts of the body).</p> <p>On 01/31/25 at 12:52 PM, the surveyor obtained a MAR audit for Resident #236, which revealed the exact time that the medication was signed off, which indicated 01/30/25 at 08:16 AM.</p> <p>On 01/31/25 at 12:53 PM, the surveyor reviewed the concern with the DON regarding Resident #236 's medication administration observation and MAR audit review.</p> <p>On 01/31/25 at 12:57 PM, the DON completed a pill count of the Bicalutamide medication with the Unit Manager/Staff #5 and the surveyor present. There were 26 pills counted to be in the bottle.</p> <p>On 01/31/25 at 12:58 PM, the surveyor observed a date of 1/27/25 on the pill bottle (which indicated the first date of which a pill was taken out the bottle).</p> <p>On 01/31/25 at 12:58 PM, an interview with the DON who was present during the observation revealed that the date written in would be the date a staff member opened the bottle.</p> <p>On 01/31/25 at 12:59 PM, the surveyor obtained the medication bottle of Bicalutamide, which indicated a quantity of 30 pills were in the bottle prior to being opened.</p> <p>On 01/31/25 at 01:07 PM, an interview with the DON revealed that if medication had been given each day since the bottle was opened on 1/27/25, then there would be a total of 25 pills left in the bottle at the time of the pill count. She was in agreement with the medication error finding.</p> <p>2) On 01/31/25 at 07:20 AM, the surveyor observed Registered Nurse (Staff #23) administer Ophthalmic solution 0.5% carboxymethylcellulose, 2 drops into each of Resident #9's eyes (right and left).</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/31/25 at 08:02 AM, review of Resident #9's order for Ophthalmic solution 0.5% carboxymethylcellulose revealed, 1 drop into each of Resident #9's eyes (right and left).</p> <p>3) On 01/31/25 at 07:33 AM, the surveyor observed Staff #23 administer OcuSoft Lid Scrub to Resident #16's left and right eye.</p> <p>On 01/31/25 at 07:59 AM, the surveyor reviewed the MAR for Resident #16 which revealed an order for OcuSoft Scrub to the left eye, which was signed off for the 8:00 AM administration.</p> <p>On 01/31/25 at 12:53 PM, the surveyor reviewed the concern with the DON regarding Resident #9 and #16's medication administration observations.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>50573</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to ensure a resident was free from a significant medication error. This was evident for 1 (Resident #236) of 5 resident medication administrations observed during the survey.</p> <p>The findings include:</p> <p>On 01/30/25 at 08:02 AM, the surveyor observed Registered Nurse Supervisor (RN) #22 administer 4 medications to Resident #236.</p> <p>On 01/30/25 at 08:15 AM, the surveyor observed RN #22 document the medications, which revealed 5 medications being signed off as administered, which included Bicalutamide 50MG, which was not observed to be prepared or administered to Resident #236.</p> <p>On 01/30/25 at 08:26 AM, review of Resident #236 Medication Administration Record (MAR) revealed 5 medications signed off, including Bicalutamide Tablet 50 MG (A drug used with another drug to treat prostate cancer that has spread to other parts of the body).</p> <p>On 01/31/25 at 12:52 PM, the surveyor obtained a MAR audit for Resident #236, which revealed the exact time that the medication was signed off, which indicated 01/30/25 at 08:16 AM.</p> <p>On 01/31/25 at 12:53 PM, the surveyor reviewed the concern with the DON regarding Resident #236's medication administration observation and MAR audit review.</p> <p>On 01/31/25 at 12:57 PM, the DON completed a pill count of the Bicalutamide medication with the Unit Manager/Staff #5 and the surveyor present. There were 26 pills counted to be in the bottle.</p> <p>On 01/31/25 at 12:58 PM, the surveyor observed a date of 1/27/25 on the pill bottle (which indicated the first date of which a pill was taken out the bottle).</p> <p>On 01/31/25 at 12:58 PM, an interview with the DON who was present during the observation revealed that the date written in would be the date a staff member opened the bottle.</p> <p>On 01/31/25 at 12:59 PM, review of the medication bottle label of Bicalutamide revealed a quantity of 30 pills, which indicated the amount of pills that were in the bottle prior to being opened.</p> <p>On 01/31/25 at 12:59 PM, further review of the medication bottle of Bicalutamide revealed administration instructions that read, take or use this medicine exactly as directed do not skip doses or discontinue unless directed by your doctor.</p> <p>On 01/31/25 at 01:07 PM, an interview with the DON revealed that if medication had been given each day since the bottle was opened on 1/27/25, then there would be a total of 25 pills left in the bottle at the time of the pill count. She was in agreement with the significant medication error finding.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/31/2025
NAME OF PROVIDER OR SUPPLIER  Pickersgill Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE  615 Chestnut Avenue 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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50457</p> <p>Based on observations and interviews, it was determined that the facility staff failed to ensure canned goods and dry food were labeled with expiration dates and failed to label opened food with a used by date. This deficient practice was evident during the kitchen observation and has the ability to impact all residents who receive food from the kitchen.</p> <p>The findings include:</p> <p>On [DATE] at 10:33 AM, during an initial tour of the facility's kitchen with the Director of Dietary Services (DDS) #24 and Dietary Chef #25, the surveyor observed a rack of canned goods without an expiration date. When asked about the process for determining when to discard outdated canned goods the DDS #24 stated they were unsure and deferred the question to the Kitchen Chef #25. The Kitchen Chef #25 explained that can goods are ordered frequently, but the kitchen does not have a process in place to track expiration or best by date for canned goods.</p> <p>Next to the canned good rack, the surveyor along with the DDS #24, and Dietary Chef #25 observed an open cardboard box of Kellogg's Club Crackers containing individual packets. No expiration date was found on either the box or the individual cracker packets. When the surveyor inquired about the date the box was opened and expiration date, the DDS #24 and Dietary Chef #25 were unable to determine when it was opened or when it expired.</p> <p>At 10:40 AM, during a tour of the dairy refrigerator, the surveyor observed an open carton of heavy whipping cream without a label indicating the date it was opened or its discard date. When the surveyor mentioned the finding to the Dietary Chef #25, he immediately discarded the carton and acknowledged that it should have been labeled with both an open and discard date. When asked if labeling dairy products with these dates were the expectation of dietary staff, he confirmed that it was.</p> <p>On [DATE] at 01:54 PM, during a follow up tour of the facility's kitchen with the DDS #24, the surveyor observed that all canned goods were labeled with expiration dates, and the observed open box of Kellogg's Club Crackers had been discarded.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/31/2025
NAME OF PROVIDER OR SUPPLIER  Pickersgill Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE  615 Chestnut Avenue Towson, MD 21204	

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>50573</p> <p>Based on observation, record review and staff interview, it was determined the facility failed to conduct regular inspection of all bed frames, mattresses, and bed rails to identify areas of possible entrapment. This was evident for 2 (Resident #31 and #13) of 2 residents reviewed for accidents hazards.</p> <p>The findings include:</p> <p>Bedrails or side rails are adjustable bars that attach to the bed. They vary in size, including full, half, and quarter lengths depending on their intended purpose. They can be used to prevent falls, help assist residents with movement, and provide a feeling of security. Bed rails also have potential risks associated with them.</p> <p>1) On 01/29/25 at 08:14 AM, during the initial phase of the survey, the surveyor observed Resident #31 in bed with two 1/4 bed rails up on either side of the top end of the bed.</p> <p>2) On 01/29/25 at 10:05 AM, during the initial phase of the survey, the surveyor observed Resident #13's bed in his/her room which revealed two 1/4 bed rails up on either side of the top end of the bed.</p> <p>On 01/30/25 at 11:17 AM, an interview with the Director of Maintenance (Staff #13) revealed that he would be unable to provide documentation of routine bedrail entrapment assessments completed for Resident #13 and #31. He indicated that maintenance completed routine checks of resident rooms, which did not include risk of entrapment assessments for those residents with transfer bars/bed rails.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/31/2025
NAME OF PROVIDER OR SUPPLIER  Pickersgill Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE  615 Chestnut Avenue Towson, MD 21204	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>50573</p> <p>Based on record review and interview, it was determined that the facility failed to ensure there was a system in place to ensure Geriatric Nursing Assistants (GNAs) completed 12 hours of in-service training annually. This was evident for 3 (GNA #7, GNA #19, GNA #21) of 5 GNAs reviewed during the survey.</p> <p>The findings include:</p> <p>1) On 01/30/25 at 3:19 PM, review of GNA #7's employee file revealed that Staff #7 received 3 hours of in-service training in 2024.</p> <p>2) On 01/30/25 at 3:21 PM, review of GNA #19's employee file revealed that Staff #19 received 5 hours of in-service training in 2024.</p> <p>3) On 01/30/25 at 3:24 PM, review of GNA #21's employee file revealed that Staff #21 received 0 hours of in-service training in 2024.</p> <p>On 01/31/25 at 10:10 AM, an interview with the Director of Nursing (DON) revealed that the facility was not in compliance with the 12 hour GNA annual in-service training for Staff #7, Staff #19, and Staff #21.</p>		