

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/23/2025
NAME OF PROVIDER OR SUPPLIER  Sherrill House		STREET ADDRESS, CITY, STATE, ZIP CODE  135 South Huntington Avenue Boston, MA 02130	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>41107</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was severely cognitively impaired, and was dependent on staff to meet his/her care needs, the Facility failed to ensure that on 10/29/24, after Facility Administration was made aware of an allegation of physical abuse, that they reported the allegation to the Department of Public Health (DPH) within two hours as required, and was not reported to the DPH until 12/06/24 (more than a month after Administration was made aware of the allegation).</p> <p>Findings include:</p> <p>Review of the Facility Policy titled Abuse Prohibition, dated as revised 12/21/23, indicated that all alleged violations of Federal and State laws which involve mistreatment, neglect, abuse, injuries of unknown source, exploitation, and misappropriation of resident property are reported immediately to the Executive Director of the Facility. Further review of the Policy indicated that such violations will also be reported to State Agencies in accordance with existing State law.</p> <p>Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated as submitted on 12/06/24, indicated that on 10/29/24 a Certified Nurse Aide (CNA) found Resident with his/her left second and third fingers discolored and painful to touch. The Report indicated that later in the day on 10/29/24, Family Member #1 reported that Resident #1 said he/she had been struck in the head and stomach multiple times by a staff member. The Report indicated that when asked (by facility staff) if he/she had been hit, Resident #1 said he/she had not been.</p> <p>The Report further indicated that Family Member #1 later retracted the allegation and therefore the Facility had not reported the allegation of physical abuse to the DPH.</p> <p>The Facility was unable to provide any documentation to support that Family Member #1 had recanted his reporting of the allegation of physical abuse.</p> <p>Review of the Facility's Internal Investigation Report, dated 10/29/24, indicated that Family Member #1 said that Resident #1 alleged he/she had been punched in the head and stomach by a staff member. The Report indicated that Resident #1 did not say to Facility staff that he/she had been punched or struck by a staff member. The Report indicated that because Family Member #1 retracted his reporting of Resident #1's allegation, the Facility had not reported the allegation of physical abuse to the DPH.</p> <p>(continued on next page)</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/23/25 at 11:05 A.M. (which included review of her Written Witness Statement, dated 10/29/24), the Unit Manager said on 10/29/24, the Chief Clinical Officer notified her the Family Member #1 had reported an allegation of physical abuse involving Resident #1. The Unit Manager said Family Member #1 never told her that he recanted the allegation.</p> <p>During an interview on 01/23/25 at 2:54 P.M., the Director of Nurses (DON) said that on 10/29/24 sometime in the afternoon, she was notified by the Chief Clinical Officer that there was an allegation of physical abuse, which included Resident #1 being punched in the head and stomach by a staff member. The DON said she interviewed Resident #1 and he/she told her (DON) that he/she had not been punched.</p> <p>The DON said that Family Member #1 then recanted their reporting of the allegation of physical abuse, so she did not report the allegation of abuse to the DPH on 10/29/24. The DON said DPH called her in December (could not remember the exact date), and told her that the DPH had received report of an allegation of abuse that occurred on 10/29/24 involving Resident #1, and requested that they submit a report and their investigation.</p> <p>During an interview on 01/23/25 at 10:35 A.M., the Chief Clinical Officer (CCO) said that on 10/29/24, he received an allegation of abuse involving Resident #1 that he/she had alleged being punched by a staff member. The CCO said he was not in the Facility at the time, but said he immediately notified the DON and Unit Manager about the allegation of abuse. The CCO said he assumed the allegation of physical abuse had been reported to DPH on 10/29/24, but later found out, that it had not been.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>41107</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had severe cognitive impairment and was dependent on staff to meet his/her care needs, the Facility failed to ensure that on 10/29/24, after being made aware of an allegation that he/she had been physically abused by a staff member, they obtained and maintained evidence that a thorough investigation into the allegation had been completed and that a summary of their investigation findings was submitted to the Department of Public Health within five days, as required.</p> <p>Findings include:</p> <p>Review of the Facility's Policy titled, Policies and Procedures Regarding Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source, and Misappropriation of Resident's Property, Exploitation, Adverse Event, or Retaliation, dated as revised 12/21/23, indicated the following:</p> <ul style="list-style-type: none"> <li>-The investigation shall include interview of associates, visitors, or residents who may have knowledge of the alleged incident. Factual information should be documented, not assumptions or speculations. Written statements from involved parties should be obtained. The documentation of the investigation shall be kept in the Executive Director's office in an administrative file, and</li> <li>- Federal law requires the Facility to have evidence of investigation of alleged violations. The Verification of Investigation form shall be completed after the investigation is complete and provided to survey agencies when requested or required by State or Federal law.</li> </ul> <p>Resident #1 was admitted to the Facility in October of 2019, diagnoses included Alzheimer's Disease, bipolar disorder, and dementia.</p> <p>Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 09/12/24 indicated he/she had severe cognitive impairment and was dependent on staff for care.</p> <p>Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated as submitted 12/06/24, indicated that sometime in the morning on 10/29/24, Certified Nurse Aide (CNA) #1 found Resident with his/her left second and third fingers discolored and painful to touch. The Report indicated that Resident #1 had most likely gotten his/her hand stuck in the spoke(s) of the wheelchair. The Report indicated that later in the day on 10/29/24, Family Member #1 reported that Resident #1 said he/she had been punched in the head and stomach multiple times by a staff member. The Report indicated that when asked if he/she had been hit, Resident #1 said he/she had not been, and that staff felt Resident #1 had not been abused.</p> <p>Review of the Facility's Internal Investigation Report, dated 10/29/24, indicated that on the morning of 10/29/24, Resident #1 was found to have bruising on his/her left second and third fingers, and the Facility had determined that he/she (Resident #1) had injured his/her fingers in his/her wheelchair spokes. The Report indicated that on 10/29/24, an allegation that Resident #1 had been punched in the head and stomach by a staff member had been reported to Facility Administration to (by a family member) sometime in the afternoon that day.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Although the Investigation included Written Witness Statements from facility staff, their statements only pertained to the bruising on Resident #1's fingers. There was no documentation in the Witness Statements from staff that indicated they were even questioned or asked if they had ever witnessed a staff member physically abuse Resident #1, or if Resident #1 had ever reported to any of them that he/she had been hit by a staff member.</p> <p>The Investigation Report indicated that an allegation of abuse had not been reported to the DPH or investigated because Family Member #1, who initially reported the allegation of physical abuse to the Chief Clinical Officer on 10/29/24, had recanted.</p> <p>During an interview on 01/23/25 at 11:05 A.M. (which included review of her Written Witness Statement, dated 10/29/24), the Unit Manager said that on 10/29/24 sometime in the morning, CNA #1 told her that Resident #1 had bruising on his her left second and third fingers. The Unit Manager said she was not aware that there was an allegation of physical abuse involving Resident #1 until the Chief Clinical Officer notified her and the Director Of Nurses on 10/29/24 sometime in the afternoon.</p> <p>The Unit Manager said that once she was made aware of the allegation, she asked Resident #1 if anyone had punched him/her and said Resident #1 did not answer her. The Unit Manager said her written witness statement focused the bruises on Resident #1's fingers, and not the allegation of physical abuse.</p> <p>During an interview on 01/23/25 at 2:54 P.M., The Director of Nurses (DON) said that on 10/29/24, sometime in the morning, the Unit Manager told her that Resident #1 had bruises on his/her left second and third fingers. The DON said she investigated the injuries and determined that the bruises on Resident #1's fingers were from his/her wheelchair.</p> <p>The DON said later that day 10/29/24, she was made aware that there was an allegation of physical abuse by a staff member, involving Resident #1. The DON said she had not fully investigated the abuse allegation because Family Member #1 who had reported it, had recanted. The DON said she could not provide any documentation to support that Family Member #1 recanted the allegation. The DON said she also could not provide documentation of interviews to support that she or any other staff member had conducted interviews with Resident #1, Family Member #1, or staff specific to the abuse allegation. The DON said she could not provide written witness statements from staff members pertaining to the allegation of physical abuse.</p> <p>During an interview on 01/25/25 at 10:35 A.M., the Chief Clinical Officer (COO) said that he believed he was the first person to receive the allegation of physical abuse involving Resident #1 on 10/29/24, and that he had immediately notified the DON and the Unit Manager. The COO said the Facility should have conducted an investigation into the allegation of physical abuse, and not just Resident #1's bruised fingers, but they had not. The COO said an investigation should include staff member statements and/or interviews specifically pertaining to the allegation of abuse. The COO said the person reporting the allegation should have been interviewed but said there was no documentation to support that had been done. The COO said an attempt to identify any accused staff members should have been made via the investigation but was not.</p>		