STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225201	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherrill House	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 40702 Based on records reviewed and interviews, for one of three sampled residents, (Resident #1), who upon admission, had Orthopedic recommendations for nursing to monitor his/her left wrist and cast, the Facility failed to ensure they maintained a complete and accurate medical record, when the Orthopedic recommendations were not transcribed by nursing onto his/her Treatment Administration Record (TAR), and therefore was no nursing documentation on the TAR to support nursing monitored Resident #1's left wrist/cast. Findings Include: Review of the Facility's Policy tilted Charting and Documentation, dated as last revised April 2008, indicated the following: -all services provided to the resident to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record -all observations, medications administered, services performed, etc., must be documented in the resident's clinical records Resident #1 was admitted to the Facility in February 2025, diagnoses included dementia, history of falling, fracture of lower end of left radius (bone located on the thumb side of the forearm), fracture of other parts of neck, and hypertension. Review of Resident #1's Hospital Discharge Summary, dated 02/12/25, indicated that his/her principal diagnosis was a fall resulting in a C3 (cervical vertebra) spinous process fracture (a break in the bony projection on the back of the C3 vertebra) and a left distal radius fracture. The Summary further indicated that Resident #1's left wrist was casted and included Orthopedic discharge recommendations to monitor for the following: -cast to kept clean and dry -if he/she starts to feel pain, numbness or tingling, elevate and ice the affected extremity -if it persists, despite elevation and ice, return to the hospital or clinic, as the cast may be on too tight and may need to be changed (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Physician Orders, dated February 2025, indicated there was no documentation to support that a Physician's order related to the Orthopedic recommendations to monitor the cast to his/her left wrist was obtained. Review of Resident #1's TARs, dated February 2025, indicated there was no documentation to support that his/her left wrist/cast were being monitored by nursing staff. During an interview on 03/14/25 at 8:06 A.M., the Unit Manager said if a resident has a cast, nurses always monitor the resident for circulation, sensation, and motor function (CSM), and for any pain or signs of infection every shift, which are documented on the resident's TARs. During an interview on 03/18/25 at 10:33 A.M., the Nursing Supervisor said when a resident is admitted with a cast to one of their extremities it is common nursing practice to monitor the resident's CSM, pain and signs or symptoms of infection every shift. The Nursing Supervisor said she reviewed Resident #1's Hospital Discharge Summary upon admission to the Facility, verified his/her orders with the Physician, and entered all of the orders into the Point Click Care (PCC, electronic medical record) computer system. The Nursing Supervisor said she could not recall if Resident #1 had a cast to his/her left wrist or recall if there were orthopedic recommendations on his/her discharge summary and said she must have missed it. During an in-person interview on 03/11/25 at 3:44 P.M. and a telephone interview on 3/14/25 at 10:50 A.M., the Director of Nursing (DON) said if a resident is admitted with a cast to an extremity due to a fracture, nursing should be monitoring the resident's CSM and for signs and symptoms of pain every shift. The DON said she could not recall if Resident #1 had a left radius fracture or a cast to his/her left wrist upon admission and said she was not aware that there were orthopedic recommendations on his/her Hospital Discharge Summary. The DON said it is her expectation that nurses are properly reviewing each resident's discharge summaries and that there should not be any orders or recommendation missed.