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	04/07/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 43963 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who was alert, oriented and made his/her own health care decisions, the Facility failed to ensure that he/she was fully informed in advance and given information including the risk and benefits of psychotropic medications prior to their use, when Resident #1 was administered nine (9) doses of an antipsychotic medication by nursing, before obtaining his/her consent to administer the medication. Findings include: Review of the Facility Policy titled, Resident Rights, undated, indicated that residents have the right to a dignified existence and to communicate with individuals and representatives of choice and the Facility will protect and promote your rights. The Policy further indicated that all residents have the right to be fully informed of their total health status in an understandable manner. Resident #1 was admitted to the Facility in February 2025 diagnoses included Respiratory Syncytial Virus (RSV, a virus that infects the lungs and respiratory tract) with pneumonia, new onset of seizures, and a nasal gastrostomy tube (tube inserted through the nose to the stomach used for temporary medical purposes) placed for nutritional purposes. Review of Resident #1's Admission Minimum Data Set (MDS) Assessment, dated 02/11/25, indicated he/she was alert, oriented, was his/her own decision maker, and had scored a 14/15 on his/her Brief Interview for Mental Status (BIMS) Assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired cognition, and 12-15 suggests a resident is cognitively intact). Review of Resident #1's Physician's Order, for February 2025, indicated he/she had a new Physician's Order for nursing to administer; -Quetiapine (Seroquel, antipsychotic medication) 25 milligrams (mg), administer one tablet by mouth at bedtime for agitation; and -Quetiapine 25 mg, administer one half tablet (12.5 mg) by mouth every eight (8) hours as needed (PRN) for agitation. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Medication Administration Record (MAR), dated 02/04/25 through 02/11/25, indicated he/she received a total of 9 doses of Quetiapine, before the Facility obtained signed written consent from him/her on 2/12/25, to administer the psychotropic medication. Review of Resident #1's Informed Consent for Psychotropic Administration Form, dated 02/12/25, indicated he/she gave consent for the administration of Quetiapine eight days after admission. During an interview on 04/07/25 at 5:06 P.M., Nursing Supervisor #1 said that she was the nurse completed Resident #1's admission and does not know why his/her psychotropic medication consent form had not been signed. Nursing Supervisor #1 said that the nurse responsible for admitting the resident is responsible for obtaining all consents. During an interview on 04/07/25 at 3:49 P.M., the Unit Manager said that she was unaware that Resident #1's psychotropic medication consents were not obtained in a timely manner. The Unit Manager said that the nurse admitting the resident is responsible for obtaining consents, including residents with physicians' orders for psychotropic medications. The Unit Manager said a consent form, for administration of psychotropic medications needs to be signed by the resident, or if the residents' Health Care Proxy is invoked then the form would need to be signed by the Health Care Agent. During an interview on 04/07/25 at 4:45 P.M., the Director of Nurses (DON) said that written consent for the administration of Quetiapine was not obtained upon admission for Resident #1, or prior to it being administered to him/her. The DON said the Facility's expectation is that the nurses are to obtain written consent and have the form signed for psychotropic medication prior to administering any psychotropic medication.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 43963 Based on records reviewed and interviews, for three of three sampled residents, (Resident #1, #2, and #3), the facility failed to ensure that upon admission, that nursing developed and implemented baseline care plans with interventions, treatments, goals, and outcomes that addressed the residents' overall immediate care needs. Findings include: Review of the Facility Policy titled Baseline Care Plans, dated as last revised 12/2016, indicated a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight hours of admission. The Policy indicated that the Interdisciplinary Team (IDT) will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the resident's immediate care needs including but not limited to; -Initial goals based on admission orders; -Physician Orders; -Dietary Orders; -Therapy Services; -Social Services; and -Pre-admission Screening and Resident Review (PASRR) recommendations, if applicable. The Policy further indicated that the baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an IDT person-centered care plan. 1) Resident #1 was admitted to the Facility in February 2025 diagnoses included Respiratory Syncytial Virus (RSV, a virus that infects the lungs and respiratory tract) with pneumonia, new onset of seizures, and a nasal gastrostomy tube (tube inserted through the nose to the stomach used for temporary medical purposes) placed for nutritional purposes. Review of Resident #1's Hospital Discharge Summary, dated 02/04/25, indicated his/her immediate care needs were identified as followed; -New onset of seizures with new antiseizure medications; -RSV with suspected aspiration pneumonia (caused by drawing in debris into the lung) with the use of oxygen via nasal cannula at three (3) liters (l); (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nasogastric- tube in place for caloric needs; and -Agitation with new administration of antipsychotic medication. Review of Resident #1's Medical Record indicated there was no documentation to support that Baseline Care Plans were developed and implemented, or that Comprehensive Care Plans that addressed these areas of concern were in place within 48 hours of his/her admission. 2) Resident #2 was admitted to the Facility in November 2024 diagnoses include diabetes mellitus, depression, chronic pain syndrome, End Stage Renal Disease (ESRD) requiring dialysis, anemia, and Chronic Obstructive Pulmonary Disease (COPD). Review of Resident #2's Skilled Nursing Facility (SNF) Transfer paperwork, dated 11/27/24, indicated his/her immediate care needs were identified as followed; -Major Depression with psychotropic medication use; -Chronic Pain Syndrome with daily narcotic use and constipation; -Diabetes Mellitus; and -COPD with compromised respiratory status. Review of Resident #2's Medical Record indicated there was no documentation to support that Baseline Care Plans were developed and implemented, or that Comprehensive Care Plans that addressed these areas of concern were in place within 48 hours of his/her admission. 3) Resident #3 was admitted to the Facility in March 2025 diagnoses include Congestive Heart Failure (CHF), atrial fibrillation with flutter, and Myocardial Infarction (MI). Review of Resident #3's Hospital Discharge Summary , dated 03/15/25, indicated his/her immediate care needs were identified as followed; -CHF with the need for daily weights; -Risk for an alteration in nutrition, requiring a No Added Salt (NAS) diet; and -Risk for dehydration related to diuretic use. Review of Resident #3's Medical Record indicated there was no documentation to support that Baseline Care Plans were developed and implemented, or that Comprehensive Care Plans that addressed these areas of concern were in place within 48 hours of his/her admission. During a telephone interview on 04/14/25 at 10:06 A.M., Nurse #2 said that the nurses on the floor are not responsible for creating Baseline Care Plans for the residents upon admission and that the Unit Manager does them within 48 hours. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/07/25 at 5:06 P.M., Nursing Supervisor #1 said that completing a resident's baseline care plan was not her responsibility and that the Unit Manager will create the baseline care plans within 48 hours. During an interview on 04/07/25 at 3:49 P.M., the Unit Manager said that it was her responsibility to ensure Residents' Baseline Care Plans were in place within 48 hours of admission. The Unit Manager said for Resident #1, she only entered the basic care needs and missed some of his/her required immediate care needs. The Unit Manager said that Unit Managers and/or the Charge Nurses are responsible for ensuring baseline care plans are in place within 48 hours so that staff are aware of their major needs until the comprehensive care plan is completed. During an interview on 04/07/25 at 4:45 P.M., the Director of Nurse (DON) said that she was not aware that the baseline care plans for these residents had not been completed in a timely manner. The DON said that it is the Facility's expectation that all resident's have a complete baseline care plan in place within 48 hours after admission that allows the staff to provide care and services that each resident requires.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43963 Based on records reviewed and interviews for one of three sampled residents (Resident #1) who had been maintained on oxygen via nasal cannula while at the Hospital, the Facility failed to ensure nursing staff provided care and services that met professional standards of practice, when despite Resident #1's continued need for oxygen, there was no physician order obtained for administration. Findings include: Review of the Facility Policy titled Medication and Treatment Orders, dated as [NAME] revised 07/2016, indicated that all medication and treatment orders will be consistent with principles of safe effective order writing and shall only be administered upon the written order of a person duly licensed and authorized to prescribe such medications and treatments in this state. Review of the Facility Policy titled Oxygen Administration, dated as last revised 10/2010, indicated to first verify that there is a physician's order in place. Resident #1 was admitted to the Facility in February 2025, diagnoses included Respiratory Syncytial Virus (RSV, a virus that infects the lungs and respiratory tract) with pneumonia, new onset of seizures, and a nasal gastrostomy tube (tube inserted through the nose to the stomach used for temporary medical purposes) placed for nutritional purposes. Review of Resident #1's Hospital Discharge (DC) Summary, dated 02/04/25, indicated that he/she had been maintained on three (3) Liters (l) of oxygen via nasal cannula secondary to RSV and pneumonia. Further review of the DC summary indicated that Resident #1 had been stable on room air at the time of his/her discharge. Review of Resident #1's Admission Nursing Assessment, dated 02/04/25, indicated he/she had been on oxygen via nasal cannula (however, no specific liter flow was noted). Review of Resident #1's Medication Administration Record and Treatment Administration Record, for February 2025, indicated there was no physicians order for the administration of oxygen, and parameter for liter flow. Review of Resident #1's Nurse Progress Note, dated 02/12/25, indicated he/she was being administered oxygen via nasal cannula (NC, tube that is places in the nares (nose) to provide oxygen flow) at two (2) l. Review of Resident #1's Nurse Practitioner Progress Note, dated 02/12/25, indicated to titrate (continuously measure and adjust) his/her oxygen as appropriate. During an interview on 04/07/25 at 3:49 P.M., the Unit Manager said that the nurse responsible for reconciling medications and entering the physician's orders into Point Click Care (PCC, the electronic medical record), are responsible for obtaining all medication and treatment orders upon admission. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 04/14/25 at 9:53 A.M., the Assistant Director of Nurses (ADON) said that Resident #1 required the use of oxygen upon admission, but said she was unaware that nursing had not obtained a physician's order. During an interview on 04/07/25 at 4:45 P.M., the Director of Nurses (DON) said that she knew Resident #1 required the use of oxygen, however not aware that Resident #1 did not have a physician's order to administer oxygen The DON said that it is the Facility's expectation that upon admission all medication and treatments require a physician's order to administer any medication and/or treatment before providing the medication and/or treatment.