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 01/16/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations and interviews, the facility failed to provide a dignified experience for the residents of the facility by 1) failing to provide a dignified dining experience for the residents on the first floor unit, 2) ensuring a staff member was not on the phone while providing care for one Resident (#129) and 3) ensuring staff members were not storing person items in the room of one Resident (#38), out of a total sample of 34 residents. Findings include: Review of the facility policy titled, Quality of Life - Dignity, dated 2001, indicated the following: -Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. -Residents should be treated with dignity and respect at all times. -Staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis or needs. Review of the facility's Resident Rights policy dated, August 2017, indicated: The facility is responsible to care for you in a manner and environment that enhances or promotes your quality of life. The facility is responsible to treat you with dignity and full recognition of your individuality. 1. The following was observed on the first floor unit on 1/14/25: -At 8:35 A.M., a nurse was observed standing while assisting a resident with his/her meal. The nurse was not at eye level with the resident. (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: 225201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 9:07 A.M. the surveyor observed a staff member passing out breakfast trays in the hallway for the first-floor unit. The staff member said he/she is not a feeder; he/she is right there. He/She is not going to eat it while pointing at a Resident who was sitting less than five feet away from the staff member. The following was observed on the first floor unit on 1/15/25: -At 8:23 A.M., staff were referring to residents as feeders in an area where residents could hear and a staff member was observed feeding a resident while standing and not at eye level of the resident. -At 8:47 A.M., two staff members reviewing meals at the meal truck referred to residents as feeders with residents nearby and able to hear. -At 12:35 P.M., a staff member was observed standing at the side of a resident's bed while assisting the resident with his/her meal. The staff was not at eye level with the resident and was standing over him/her. -At 5:10 P.M., a staff member was feeding a resident who was sitting in a standard wheelchair while sitting in an elevated chair, not at the level of the resident. The following was observed on the first floor unit on 1/16/25: -At 8:16 A.M., a staff member was heard referring to residents as feeders in the dining room with residents present. During an interview on 1/16/25 at 8:03 A.M., Unit Manager #1 said staff should be sitting at the resident's level when assisting with meals and should not refer to residents with labels such as feeders. During an interview on 1/16/25 at 10:17 A.M., the Director of Nursing said staff should be sitting at the resident's level when assisting with meals and should not refer to residents with labels such as feeders. 48990 2.) Resident #129 was admitted to the facility in September 2023 with diagnoses including progressive supranuclear palsy (a brain disorder that affects movement, vision, speech, and thinking ability) and dysphagia (difficulty swallowing). Review of the most recent Minimum Data Set (MDS) assessment, dated 11/23/24, indicated Resident #125 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out of 15. This MDS also indicated Resident #129 required set-up/clean-up assistance with eating. During the Resident Group Interview on 1/15/25 at 1:30 P.M., all participants said that Certified Nursing Assistants (CNA's) frequently are on their personal phones on the unit. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #129's plan of care related to activities of daily living, revised 1/14/25, indicated he/she required set-up assistance for meals. On 1/14/25 at 9:32 A.M., the surveyor entered Resident #129's room. There was a Certified Nurse Assistant (CNA) sitting in Resident #129's room who immediately put down her cellular phone. The cellular phone dropped to the ground at the surveyors' feet. The cellular phone screen clearly displayed a person's name and a length of call time of greater than 8 minutes. The CNA declined to answer any of the surveyor's questions. On 1/14/25 at 9:34 A.M., the surveyor attempted to ask Resident #129 questions about the staff member in his/her room, but Resident #129 stared blankly and did not respond to questions. During an interview on 1/15/25 at 12:09 P.M., Unit Manager #2 said staff members should never use their cell phones in any resident room. During an interview on 1/16/25 at 8:38 A.M., the Director of Nursing (DON) said the facility policy is that staff should never use their cell phones on the unit and should definitely not use their cell phones in a resident room. 36876 3. Resident #38 was admitted to the facility in August 2019 with diagnoses including dementia and mild cognitive impairment. Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #38 is severely cognitively impaired evidenced by a score of 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam. On 1/15/25 at 8:37 A.M., the surveyor observed Resident #38 laying in bed. A cell phone was plugged in and charging on the windowsill of his/her room. Resident #38 was unable to say if the phone belonged to him/her. On 1/15/25 at 10:16 A.M., the surveyor observed Resident #38 resting in bed. The cell phone was no longer on the windowsill and the charger was still plugged into the wall. During the Resident Group Interview on 1/15/25 at 1:30 P.M., all participants said that Certified Nursing Assistants (CNA's) frequently are on their personal phones on the unit and also charge their personal phones in resident rooms. One participant said that CNA's have asked him/her if they could borrow their outlet to charge their phones. On 1/16/25 at 7:30 A.M., the surveyor observed Resident #38 asleep in bed. There was no cell phone or charger in the room. During an interview on 1/16/25 at 7:44 A.M., Unit Coordinator #1 said that Resident #38 has a landline in his/her room to make calls to his/her family. Unit Coordinator #1 said that usually, the family will contact the facility to set up a Zoom call and then staff use a tablet to facilitate the call. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/16/25 at 7:57 A.M., the Director of Nursing (DON) said that staff should not be utilizing resident spaces to charge their phones.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on observations, interviews and record review, the facility failed to ensure that one Resident (#144) did not self-administer medications out of a total sample of 34 residents. Specifically, Resident #144 was observed with a card of pills left at bedside for self-administration without being assessed for self-administration. Findings include: Review of the facility policy titled 'Self-Administration of Drugs' dated August 2006, indicated the following but not limited to: -Residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so. -As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering. -If the staff determine that a resident a resident cannot safely self-administer medications, the nursing staff will administer the resident's medication. Review of facility policy titled 'Storage of Medications' dated April 2007, indicated the following but not limited to: -The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Resident #144 was admitted to the facility in December 2024 with diagnoses including ulcerative chronic proctitis, peripheral vascular disease. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident score a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. On 1/14/25 at 9:04 A.M., the surveyor observed a card of medications on the Resident s bedside table, with five pills in them, the label on the card was as follows sulfasalazine 500mg give 2 tabs by mouth twice daily. On 1/15/25 at 8:05 A.M., the surveyor and Charge Nurse #3 observed the medication card on the Resident's bedside table. The Resident stated a nurse had given him/her the card a couple of days ago. The card had three pills left. Review of the medical record failed to indicate that the Resident had been assessed for self- administration. During an interview on 1/15/25 at 8:35 A.M., Charge Nurse #3 said the Resident had not been assessed for self-administration and should not have any medications left by bedside. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/25 at 12:24 P.M., the Director of Nursing said the Residents should not have medication by bedside if they have not been assessed for self-administration.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 48990 Based on interviews and record review, the facility failed to ensure one Resident's (#150) personal care choices were honored, out of a total sample of 34 residents. Specifically, the facility failed to provide showers for Resident #150 per his/her request and preference. Findings include: Review of the facility policy titled 'Quality of Life - Self Determination and Participation', revised October 2009, indicated: - Our facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. - Each resident shall be allowed to choose activities, schedules, and health care that are consistent with his or her interests, assessments, and plans of care, including: Personal care needs, such as bathing methods. Resident #150 was admitted to the facility in November 2023 with diagnoses including heart failure and bilateral lower extremity lymphedema (a chronic condition that causes swelling in the body's soft tissue). Review of the most recent Minimum Data Set (MDS) assessment, dated 11/10/24, indicated Resident #150 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS also indicated Resident #150 was unable to walk and was dependent on staff for transfers and showering/bathing. On 1/14/25 at 8:02 A.M., Resident #150 told the surveyor he/she was very upset because he/she had not had a shower in four months. Resident #150 said staff told him/her they could not use the shower chair because it was too small for him/her. Resident #150 said he/she expressed concern and preference for a shower multiple times to many staff members, including the Chief Clinical Officer and Unit Manager #2. Resident #150 said staff have provided bed baths instead of showers, but that he/she never feels as clean as taking a shower. Review of Resident #150's progress note, dated 11/8/24, indicated the Resident prefers showering. Review of Resident #150's physician's order, initiated 11/26/24, indicated: - Weekly Shower Tuesday 7-3 Shift. Review of Resident #150's plan of care, revised 11/12/24, failed to indicate he/she preferred showers. During an interview on 1/15/25 at 11:52 A.M., Certified Nurse Assistant (CNA) #2 said she was consistently scheduled to provide care for Resident #150. CNA #2 said Resident #150 prefers showers. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/25 at 11:55 A.M., Nurse #1 said Resident #150 has an order for weekly showers, but has not been able to have a shower. Nurse #1 said instead of a shower, Resident #150 had been receiving bed baths, even though the physician's order was for weekly showers. Nurse #1 declines to answer any questions regarding why a shower was unable to be provided and refers the surveyor to Unit Manager #2. During an interview on 1/16/25 at 8:12 A.M., Unit Manager #2 said Resident #150 had been unable to have his/her shower preference accommodated because there was not a shower chair that could be safely used. Unit Manager #2 said the shower chair available was too small for his/her body size. Unit Manager #2 said when staff would move the shower chair, while containing Resident #150, it would buckle unsafely because of the weight. Unit Manager #2 said this put the CNAs and Resident #150 at risk for injury, so staff informed Resident #150 he/she could not have a shower until a safe shower chair was obtained. Unit Manager #2 said the shower chair was also physically too small, making the Resident unable to move within the chair and had no cushion which would cause pain in his/her buttocks. Unit Manager said a new safe shower chair was obtained on 1/14/24 (which was the first day of the recertification survey) and Resident #150 was able to have his/her first shower since at least the beginning of December 2024, maybe longer. During an interview on 1/15/25 at 2:31 P.M., the Chief Clinical Officer (CCO) said he was notified on 12/4/24 of the request for a larger shower chair for Resident #150. The CCO said he authorized the larger shower chair to be ordered on 12/4/24. The CCO said he spoke with Resident #150 who agreed to have bed baths until the larger shower chair came in, even though he/she said they did not like bed baths and preferred a shower. The CCO said there was no inventory completed to determine if another, larger shower chair was available for Resident #150 to use on 12/4/24. The CCO said last week he heard Resident #150 was upset because he/she still did not have a large enough shower chair, and at that time they completed a house inventory and located another, larger shower chair on another unit within the facility that Resident #150 could use. The CCO was unaware this newly located shower chair had not been used until 1/14/25 (the first day of the recertification survey). During a follow-up interview on 1/16/25 at 9:48 A.M., the CCO said he was just made aware the order for the shower chair was rejected by the distributer upon the initial order on 12/4/24. The CCO said there was a series of miscommunications, and the oversight should have been identified earlier but was not. The CCO said the facility did not consider this a grievance because they felt it was more a resident preference than a safety/care need. During an interview on 1/16/25 at 8:43 A.M., the Director of Nursing (DON) said if there were not a safe or comfortable shower chair she would expect that the facility would secure one to accommodate Resident #150's preference to shower.

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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** 41456 Based on record review, observations and interviews, the facility failed to ensure a physician's order was implemented for one Resident (#71) out of a total sample of 34 residents. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following: - Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. Resident #71 was admitted to the facility in November 2021 with diagnoses including dementia. Review of Resident #71's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident scored a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating he/she has severe cognitive impairment. The MDS also indicated Resident #71 requires set up assistance for self-feeding tasks. Review of Resident #71's medical record indicated the following physician order initiated on 4/13/22: -Weekly weights. -Torsemide (a diuretic medication used to help treat fluid retention) Tablet 10 MG (milligrams) Give 1 tablet by mouth one time a day for edema, initiated 4/12/23 Review of Resident #71's weight log indicated his/her weights were obtained monthly not weekly. Review of Resident #71's medical record indicated he/she was first prescribed torsemide (a diuretic medication) on 3/23/22, three weeks prior to the order for weekly weights. Review of Resident #71's nutritional care plan, last revised 12/20/24, indicated the following intervention: -Obtain weights per MD/PA/NP orders. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/16/25 at 7:55 A.M., Unit Manager #1 said individuals with a history of edema may receive diuretic medications in addition to non-pharmacological interventions, such as increased weights. Unit Manager #1 said Resident #71 has a history of edema and believes she is ordered to have weights taken monthly. The Unit Manage and surveyor looked at the Resident's physician orders together and the Unit Manager confirmed the Resident has an order to have weights taken weekly and said this has not been done. During an interview on 1/16/25 at 9:23 A.M., the Director of Nursing said she expects all orders to be followed as written.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record reviews and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs) for two Residents (#83 and #101) out of a total sample of 34 residents. Specifically, the facility failed to provide assistance with self-feeding tasks during mealtimes. Findings include: Review of the facility policy titled, Activities of Daily Living (ADL), Supporting, dated March 2018, indicated the following: -Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADL's. -Residents who are unable to carry out ADL's independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. -Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: d. Dining (meals and snacks). -If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate. 1. Resident #83 was admitted to the facility in September 2024 with diagnoses including dementia, nutritional marasmus and gastro-esophageal reflux disease. Review of Resident #83's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #83 requires supervision or touching assistance for self-feeding tasks. On 1/14/25 at 9:03 A.M., Resident #83 was observed eating breakfast alone in his/her room while sitting on the side of the bed. The Resident was observed pulling food out of his/her mouth. The privacy curtain next to Resident #83's bed was pulled forward, and the Resident was unable to be observed or supervised from the hallway. On 1/15/25 at 8:29 A.M., a Certified Nursing Assistant (CNA) was observed delivering Resident #83's meal to him/her in his/her room. The CNA set-up the meal and then left the room, leaving the Resident to eat alone. The privacy curtain next to Resident #83's bed was pulled forward, and the Resident was unable to be observed or supervised from the hallway. At 8:46 A.M., Resident #83 was still in his/her room still eating alone without any supervision. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 12:12 P.M., Resident #83 was observed eating lunch in his/her room alone. From 12:12 P.M. to 12:21 PM., Resident # 83 was not observed initiating eating and was just sitting with the meal in front of him/her. At 12:30 P.M., no staff had been observed to enter the Resident's room and he/she had not eaten any food and had covered his/her lunch tray with napkins. Review of Resident #83's Activity of Daily Living (ADL) care plan, last revised 1/14/25, indicated the following intervention: -EATING: continual supervision by staff with prompting/cues/refocusing to task. Review of Resident #83's nutritional care plan, least revised 1/14/25, indicated the following intervention: -Monitor my intake at every meal. Review of Resident #83's Kardex (a form indicating the level of care needed for each resident) failed to indicate the level of care the Resident required for self-feeding tasks. During an interview on 1/15/25 at 12:38 P.M., CNA #1 said the staff are usually told the level of assistance a resident requires by the nurses on the floor and was unaware of the Kardex form. CNA #1 said Resident #83 is a poor eater and does not require any assistance at mealtimes. During an interview on 1/16/25 at 8:03 A.M., Unit Manager #1 said the level of assistance a resident requires is told to the CNAs verbally and the CNAs also have the ability to look up to Kardex or care plan. Unit Manager #1 said continual supervision during meals means the resident would need to be supervised the entire meal. Unit Manager #1 reviewed Resident #83's care plan and confirmed the Resident was care planned to have continual supervision throughout meals. During an interview on 1/16/25 9:23 A.M., the Director of Nursing said care plans are created to the level of the resident's needs and expect them to be followed as written. 50338 2. Resident #101 was admitted to the facility in June 2018 with diagnoses including dementia, diabetes, and bipolar disorder. Review of the Minimum Data Set (MDS) assessment, dated 11/20/24, indicated that Resident #101 had severe cognitive impairment as evidenced by the Brief Interview for Mental Status (BIMS) staff assessment. Further review of MDS indicates that Resident #101 required partial/moderate assist for eating and that he/she had highly impaired vision. On 1/14/25 at 9:06 A.M., the surveyor observed Resident #101 sitting in wheelchair in his/her room with breakfast tray on overbed table in front of his/her. Resident #101 was using hands to find food and putting the food in his/her mouth with his/her hands. There was no staff present in the room. On 1/14/25 at 12:54 P.M., the surveyor observed Resident #101 sitting in wheelchair in his/her room with lunch tray on overbed table in front of him/her. There was no staff present in the room. Resident #101 was attempting to open can of soda that was on the lunch tray and not been setup for him/her. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Sherrill House		STREET ADDRESS, CITY, STATE, ZIP CODE 135 South Huntington Avenue Boston, MA 02130	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 9:02 A.M., the surveyor observed Resident #101 sitting in wheelchair in his/her room with breakfast tray on overbed table in front of him/her. Resident #101 was using his/her hands to find food on the tray. There was no staff present in the room. On 1/15/25 at 1:00 P.M., the surveyor observed Resident #101 in wheelchair in his/her room with lunch tray on overbed table in front of him/her. He/she was feeding him/herself. There was no staff present in the room. On 1/16/25 at 9:00 A.M., the surveyor observed Resident #101 in wheelchair in his/her room with breakfast tray on overbed table in front of him/her. He/she was feeding him/herself. There was no staff present in the room. Review of Resident #101's plan of care related to ADL's, dated 8/23/24, indicated requires assist with eating for all meals. Review of Resident #101's Kardex (a form indicating the level of care for the Resident), dated 1/16/25, indicated requires eating assist. Review of Resident #101's MDS, dated [DATE], indicated that he/she eats with partial/moderate assist. Review of Resident #101's tasks, dated 1/2/25-/15/25, indicated that he/she was supervised for all meals, but also included three episodes of requiring assist to eat and one episode of requiring dependence to eat. During an interview on 1/16/25 at 7:21 A.M., Certified Nursing Assistant (CNA) #6 said Resident #101 is set up for meals in his/her room and just needs to be checked on. CNA #6 said that Resident #101 does not like to be assisted to eat. During an interview on 1/16/25 at 9:03 A.M., CNA #5 said that she tried to assist Resident #101 to eat breakfast, but Resident #101 did not want to be assisted. During an interview on 1/16/25 at 8:33 A.M., Nurse #5 said that Resident #101 eats well, is independent. During an interview on 1/16/25 at 9:06 A.M., the Assistant Director of Nursing (ADON) said that Resident #101 needs to be fed with a large amount of encouragement. During an interview on 1/16/25 at 9:11 A.M., Nurse #6 said Resident #101 needs supervision during meals. During an interview on 1/16/25 at 9:30 A.M., the Director of Nursing (DON) said she would expect care plans to be followed as written.

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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 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe and appropriate respiratory care for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45763

Based on observations, interview, and record review, the facility failed to ensure that respiratory care and services, consistent with professional standards of practice, were provided for two Residents (#103 and #88), out of a total sample of 34 Residents. Specifically, Residents #103 and #88 the facility failed to ensure nursing consistently set his/her oxygen flow rate as ordered by the physician.

Findings include:

Review of the facility policy, titled Oxygen Administration, revised March 2004, indicated, but was not limited to, the following:

- Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.

- Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following:

o Vital signs

1). Resident #103 was admitted to the facility in January 2024 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD).

Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #103 scored an 11 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had moderate cognitive impairment. Further review of the MDS indicated Resident #103 received respiratory therapy for at least 15 minutes for seven days out of the observed seven days.

Review of Resident #103's care plans indicated the following:

- Resident #103 had an altered cardiovascular status due to coronary artery disease with the following intervention: Give oxygen as ordered by my MD/PA/NP, initiated 1/10/24.

- Resident #103 had a diagnosis of COPD with the following intervention: Provide oxygen therapy as ordered by MD/PA/NP, initiated 1/10/24.

- Resident #103 was at risk for decreased cardiac output due to coronary artery disease, with the following intervention: Provide oxygen as indicated by Resident condition and/or provider order, initiated 1/10/24.

- Resident #103 was at risk for ineffective airway clearance with the following intervention: Provide oxygen as indicated by Resident condition and/or provider order, initiated 1/10/24.

Review of Resident #103's active physician orders indicated the following orders:

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Oxygen therapy 2L(liters)/min (minute) via nasal cannula as needed to maintain oxygen saturation level greater than 90%, initiated 12/16/24. - May increase oxygen up to 4l prn (as needed) for Sat less than 90% (sic.), initiated 1/19/24. Review of Resident #103's vitals summary indicated the following oxygen saturation readings: 1/12/25 at 1:36 P.M., 97% (oxygen via nasal cannula) 1/13/25 at 3:30 P.M., 96% (oxygen via nasal cannula) 1/13/25 at 6:13 P.M., 97% (oxygen via nasal cannula) 1/14/25 at 8:36 A.M., 93% (oxygen via nasal cannula) 1/14/25 at 2:02 P.M., 97% (oxygen via nasal cannula) 1/14/25 at 4:26 P.M., 95% (oxygen via nasal cannula) 1/15/25 at 9:12 A.M., 94% (oxygen via nasal cannula) On 1/14/25 at 12:37 P.M., the surveyor observed Resident #103 in bed receiving supplemental oxygen through a nasal cannula, the Resident's oxygen concentrator was set between three and three and a half liters per minute. On 1/14/25 at 4:51 P.M., the surveyor observed Resident #103 in bed receiving supplemental oxygen through a nasal cannula, the Resident's oxygen concentrator was set between three and three and a half liters per minute. On 1/15/25 at 8:08 A.M., the surveyor observed Resident #103 in bed receiving supplemental oxygen through a nasal cannula, the Resident's oxygen concentrator was set between three and three and a half liters per minute. On 1/15/25 at 11:35 A.M., the surveyor observed Resident #103 in bed receiving supplemental oxygen through a nasal cannula, the Resident's oxygen concentrator was set between three and three and a half liters per minute. During an interview and observation on 1/15/25 at 11:37 A.M., Nurse #1 said nurses should check Resident #103's oxygen concentrator settings daily and that it should be set to 2 L/min unless the Resident's oxygen saturation was below 90%. Nurse #1 said that every time an oxygen saturation was measured it was documented in the Resident's electronic medical record. The nurse and surveyor observed Resident #103 in bed receiving supplemental oxygen through a nasal cannula. Nurse #1 measured the Residents oxygen saturation level and it was 94%, Nurse #1 then inspected the oxygen concentrator setting and said that it should be set to two liters per minute as the Resident's oxygen saturation was above 90%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/25 at 11:51 A.M. Physician #1 said that Resident #103's oxygen concentrator should only exceed 2 L/min if the Resident's oxygen saturation dropped below 90% and that if a nurse documented that Resident #103's oxygen saturation was above 90% that she would have expected the nurse to reduce the setting to two liters per minute. Physician #1 said that if a resident with COPD received too much oxygen that it could lead to carbon dioxide retention and a change in mental status. Review of Resident #103's most recent basic metabolic panel lab results, collected on 1/7/25, indicated the Resident's carbon dioxide levels were elevated. During an interview on 1/15/25 at 3:14 P.M., the Director of Nursing (DON) said she would expect orders for oxygen administration to be followed. The DON said Resident #103 used supplemental oxygen often and that the Resident's oxygen should not have been set higher than two liters per minute. 50338 2). Resident #88 was admitted to the facility in February 2021 with a diagnosis of Chronic Respiratory Failure. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #88 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident was cognitively intact. Further review of the MDS indicated Resident #88 received oxygen therapy. Review of Resident #88's active physician orders indicated the following orders: - Oxygen therapy 4L(liters)/min (minute) via nasal cannula continuously, initiated 11/25/22. Review of Resident #88's Medication Administration Record (MAR) indicated the following: -oxygen therapy 4L/min via nasal cannula continuously every shift. Review of Resident #88's care plans indicated the following: - Resident #88 was at risk for decreased cardiac output due to heart failure, with the following intervention: Provide oxygen via nasal cannula as ordered, initiated 12/28/24. - Resident #88 was at risk for impaired gas exchange, with the following intervention: Oxygen (O2) settings: O2 via nasal cannula at 4L/min continuously, initiated 2/23/21. On 1/14/25 at 8:21 A.M., the surveyor observed Resident #88 in bed receiving supplemental oxygen through a nasal cannula, the Resident's oxygen concentrator was set between one and a half and two liters per minute. On 1/14/25 at 2:07 P.M., the surveyor observed Resident #88 sitting in chair in room receiving supplemental oxygen through a nasal cannula, the Resident's oxygen concentrator was set at two liters per minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 8:15 A.M., the surveyor observed Resident #88 in bed receiving supplemental oxygen through a nasal cannula, the Resident's oxygen concentrator was set at two liters per minute. On 1/15/25 at 12:43 P.M., the surveyor observed Resident #88 sitting in chair in room receiving supplemental oxygen through a nasal cannula, the Resident's oxygen concentrator was at two liters per minute. On 1/16/25 at 6:37 A.M., the surveyor observed Resident #88 in bed receiving supplemental oxygen through a nasal cannula, the Resident's oxygen concentrator was set between one and a half and two liters per minute. During an interview and observation on 1/16/25 at 7:00 A.M., Nurse #4 Resident #88's oxygen should be set on four liters per minute. The nurse and surveyor observed Resident #88 in bed receiving supplemental oxygen through a nasal cannula, the Resident's oxygen concentrator was set between one and a half and two liters per minute. Nurse #4 said that it should be set at four liters per minute according to the physician's order and then adjusted it to the correct setting. During an interview on 1/16/25 at 7:05 A.M., the Assistant Director of Nursing (ADON) said she would expect orders for oxygen administration to be followed. During an interview on 1/16/25 at 9:30 A.M., the Director of Nursing (DON) said she would expect orders for oxygen administration to be followed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on observations record review and interviews, the facility failed to provide care and services consistent with professional standards for one Resident (#364) who required renal dialysis (a life sustaining treatment that helps the body remove extra fluids and waste products from the blood when the kidneys are not able to.) out of a total sample of 34 residents. Specifically, the facility failed to ensure clamps and pressure dressings were kept with the Resident in case of emergency related to a tunneled hemodialysis catheter (a plastic tube used for exchanging blood between a patient and a hemodialysis machine). Findings include Review of the facility policy titled 'Hemodialysis Access Care' dated September 2010, indicated the following but not limited to: -If there is major bleeding from site (post dialysis), apply pressure to insertion site and contact emergency services and dialysis center. Verify that clamps are closed on lumens. This is a medical emergency. Do not leave resident alone until emergency services arrive. Resident #364 was admitted to the facility in January 2025 with diagnoses including End stage renal disease, dependent on dialysis. Review of Resident #364's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. The MDS further indicated the Resident was dependent on dialysis. Review of Resident #364's current physician orders indicated the following: -Monitor right chest tunneled catheter for sign and symptom of bleeding, infection every shift. On 1/14/25 at 8:09 A.M., Resident #364 was observed lying in his/her bed. The surveyor did not observe emergency clamps or pressure dressings in the Resident's room. On 1/15/25 at 8:09 A.M. Resident #364 was observed lying in his/her bed. The surveyor did not observe emergency clamps or pressure dressings in the Resident's room. During an observation and interview on 1/15/25 at 8:32 A.M., the surveyor and Charge Nurse #3 did not observe emergency clamp and pressure dressing in the Residents room. Charge Nurse #3 said emergency clamp and pressure dressings should be in the Resident's room. During an interview on 1/15/25 at 12:24 P.M., the Director of Nursing said residents with tunneled dialysis catheters should have emergency clamps and pressure dressing by bedside.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48990 Based on observations and interviews, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal requirements. Specifically, 1.) The facility failed to ensure medications were dated once opened, according to manufacturer's guidelines, in two out of four medication carts observed. 2.) The facility failed to properly secure medication carts on two of four units. Findings include: Review of the facility policy titled 'Storage of Medications', revised April 2007, indicated: - The facility shall store all drugs and biological in a safe, secure, and orderly manner. - Compartments containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. - The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. 1a.) On 1/15/25 at 8:28 A.M., the surveyor and Nurse #3 observed the following in the third floor team two medication cart: - One bottle of pro-stat (liquid protein), open and undated. The pro-stat bottle label indicated to discard 3 months after opening. - One fluticasone propionate/salmeterol diskus 100 mcg (micrograms)/50 mcg inhaler, open and undated. - One bottle of dorzolamide hydrochloride and timolol maleate 2%/0.5% eye drops, open and undated. During an interview on 1/15/25 at 8:30 A.M., Nurse #3 said the pro-stat, fluticasone propionate/salmeterol diskus inhaler, and dorzolamide hydrochloride and timolol maleate eye drops were not dated but should have been because they have a shortened expiry date once opened. During an interview on 1/16/25 at 8:38 A.M., the Director of Nursing (DON) said pro-stat, fluticasone propionate/salmeterol diskus inhaler, and dorzolamide hydrochloride and timolol maleate eye drops should be dated when opened because it has a shortened expiry date once opened. 1b.) On 1/15/25 at 12:17 P.M., the surveyor and Nurse #2 observed the following in the third floor team one medication cart: (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- One bottle of pro-stat (liquid protein), open and undated. The pro-stat bottle label indicated to discard 3 months after opening. During an interview on 1/15/25 at 12:19 P.M., Nurse #2 said the pro-stat was not dated but should have been because it has a shortened expiry date once opened. During an interview on 1/16/25 at 8:38 A.M., the Director of Nursing (DON) said pro-stat should be dated when opened because it has a shortened expiry date once opened. 2.) On 1/14/25 at 8:52 P.M., the surveyor observed a second floor medication cart unlocked and unattended in the hallway with one drawer partially open. The nurse was not within sight line of the medication cart. The surveyor observed multiple medications within this medication cart. During an interview on 1/14/25 at 8:57 P.M., Unit Manager #2 said she was not sure where the nurse for that medication cart was, but the medication cart should have been locked when not within her view. On 1/14/25 at 9:00 A.M., Nurse #1 returned to the second floor medication cart. Nurse #1 said the medication cart should have been locked when not within her view, but she must have left a drawer open, so it did not lock. On 1/16/25 at 7:53 A.M., the surveyor observed a first floor medication cart unlocked and unattended in the hallway. The nurse was not within sight line of the medication cart During an interview on 1/16/25 at 7:54 A.M., Unit Manager #1 said medication carts should always be locked when the nurse is not present. During an interview on 1/16/25 8:38 A.M., the Director of Nursing (DON) said medication carts should be looked when unattended and not within the nurse's view.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41456 Based on observations and interviews, the facility failed to provide a palatable meal to the residents on the first floor unit. Findings include: On 1/14/25 at 8:34 A.M., the surveyor observed a pureed meal on a resident's meal tray. The resident was eating eggs and the other food was indiscernible and was shaped in a long brown log form. The resident did not consume the food on the tray. During the Resident Group Interview on 1/15/25 at 1:30 P.M., all participants reported that meals are served cold and sometimes unpalatable. On 1/16/25 at 9:08 A.M., a test tray was completed on the first floor unit with the following findings: -juice was 50 degrees Fahrenheit and tastes cold -oatmeal was 130 degrees Fahrenheit, was bland with a gummy texture and was warm not hot -pureed sausage was 118 degrees Fahrenheit and tasted luke warm, not hot. The sausage was shaped oddly into a brown, long log form, had a gummy consistency and tasted bland. -french toast was 110 degrees Fahrenheit and was luke warm, not hot. The french toast had a slimey layer on the top and has a gummy consistency. During an interview on 1/16/25 at 8:07 A.M., the Food Service Director said the facility uses molds for pureed foods and the molds are delivered to the facility premade and reheated when the meals are prepared. The Foods Service Director said prefrozen molds are used to save on labor because making the pureed food inhouse was labor intensive. During an interview on 1/16/25 at 9:55 A.M., the Administrator was shown a picture of the meal and said the meal did not look appealing. During an interview on 1/16/25 at 10:05 A.M., the Director of Nursing was shown a picture of the meal and said the meal did not look palatable.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45763 Based on observation and interview the facility failed to store and handle food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure that staff dated food, that staff did not store personal food with resident food and ingredients, that dented cans were not accepted into storage/circulation and that staff did not directly handle ready-to-eat food with contaminated gloves. Findings include: Review of the facility's undated policy titled Food Storage indicated, but was not limited to, the following: - Food is stored, prepared, and transported at appropriate temperatures and by methods designed to prevent contamination or cross contamination. - All stock must be rotated with each new order received. Rotating stock is essential to ensure the freshness and highest quality of the foods. o Old stock is always used first (first in - first out method). o Supervise the person designated to put stock away to make sure it is rotated properly. o Food must be dated as it is placed on the shelves o Date marking to indicate the date or day which a ready-to-eat, potentially hazardous food should be consumed, or discarded will be visible on all high-risk food. Review of the facility's undated policy titled General Food Preparation and Handling indicated, but was not limited to, the following: - Food items will be prepared to conserve maximum nutritive value, develop and enhance flavor and be free of injurious organisms and substances. - Foods are received, checked and stored properly as soon as they are delivered. - Food in broken packages or swollen cans, cans with a compromised seal, or food with an abnormal appearance or odor will not be served. - Food will be prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements to avoid manual contact of prepared foods. On 1/14/25 at 7:17 A.M. the surveyor made the following observations during the initial kitchen walkthrough: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Two bottles of cranberry juice, open and undated, with a small amount of juice remaining in the walk-in refrigerator - A bottle of orange juice open but undated in the walk-in refrigerator; there was a grayish blue wispy growth on and around the cap of the bottle. - Two containers of fresh garlic, open and undated in the walk-in refrigerator. - Sliced cheese opened and placed in an undated and unlabeled plastic sealable bag in the walk-in refrigerator. - Dairy free sliced cheddar cheese, open but undated in the walk-in refrigerator. - A container labeled strawberries in sugar open and dated 11/29 in the walk-in refrigerator. - Feta cheese opened and placed in an undated plastic sealable bag in the walk-in refrigerator. - A can of pineapples and a can of butterscotch pudding with significant dents on the can rack near the dessert preparation area. - A can of beef stew with a significant dent on a separate can rack in the main kitchen. - An individually portioned container of food, undated and unlabeled, stored in the walk-in refrigerator adjacent to resident food and ingredients. - An undated and unlabeled black plastic bag containing individually portioned food in the reach in refrigerator next to resident food. During an interview on 1/14/25 at 7:18 A.M., Dietary staff #2 said the individually portioned container of food in the walk-in refrigerator was his lunch. During an interview on 1/14/25 at 7:23 A.M., Dietary staff #3 said the black plastic bag containing individually portioned food was her lunch. On 1/14/25 at 7:55 A.M., the surveyor made the following observations in the first-floor kitchenette refrigerator: - Five bottles of cranberry juice open but undated. - One bottle of orange juice open but undated. - Three nutritionally fortified supplemental shakes open but undated. On 1/14/25 at 8:00 A.M. the surveyor made the following observations in the second-floor kitchenette refrigerator: - Two bottles of cranberry juice open but undated. (continued on next page)

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 01/16/2025
NAME OF PROVIDER OR SUPPLIER Sherrill House		STREET ADDRESS, CITY, STATE, ZIP CODE 135 South Huntington Avenue Boston, MA 02130	

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One bottle of orange juice open but undated. On 1/14/25 at 8:04 A.M. the surveyor made the following observations in the third-floor kitchenette refrigerator: - One bottle of cranberry juice open but undated. - One bottle of orange juice open but undated. - One bottle of apple juice open but undated. - One nutritionally fortified supplemental shake open but undated. On 1/14/25 at 8:08 A.M. the surveyor made the following observations in the fourth-floor kitchenette refrigerator: - Three bottles of cranberry juice, open but undated. - Two bottles of orange juice open but undated. - Three bottles of apple juice open but undated. - One nutritionally fortified supplemental shake open but undated. - A half gallon of milk open but undated, the milk had a sour smell. During a continuous observation of the breakfast tray line service on 1/16/24 from 8:00 A.M. until 8:18 A.M. the surveyor made the following observations: - The server contaminated his gloves by grabbing utensils, the bottom of plates, and the bottom of four pre-portioned puree mold containers. The server then, using the same contaminated gloves, grabbed four slices of ready-to-eat french toast; he cut them in half and using the same contaminated gloves placed them on resident plates to be served. - The server then further contaminated his gloves by opening the food warming container by grabbing the containers door handle, by grabbing tongs, and by grabbing a large plastic container of utensils in order to move it. The server then, using the same contaminated gloves grabbed four slices of ready-to-eat french toast; he cut them in half and using the same contaminated gloves placed them on resident plates to be served. - The server then further contaminated his gloves by opening the food warming container by grabbing the containers door handle and with the same contaminated gloves grabbed two slices of ready-to-eat french toast; he cut them in half and using the same contaminated gloves placed them on resident plates to be served. - The server failed to change his gloves or wash his hands throughout the continuous observation. (continued on next page)

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 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherrill House	135 South Huntington Avenue Boston, MA 02130

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/14/25 at 7:46 A.M., the Executive Chef said that the staff member who received the cans and put them away should check for dents and that dented cans should be set aside, not placed into circulation with the other cans on the can rack. The executive chef said that the beef stew, pineapple, and pudding cans should have been set aside/discarded and not placed in the can racks to be used. The executive chef said the wispy growth on the outside of the orange juice cap was mold and that containers of juice should be dated when opened. During an interview on 1/16/25 at 7:42 A.M., the Food Service Director (FSD) said that food should be labeled and dated when opened or prepared and discarded after three days. The FSD said that nursing staff should be dating bottles of juice and supplements when they open them. The FSD said the employees have a designated refrigerator for their food and that they should not be storing their personal food with resident food or ingredients. The FSD said that the strawberries in sugar should have been discarded. The FSD said that cans should be inspected when received and cans with dents should be set aside to be returned to the supplier; the FSD said that the cans with dents should not have been placed into rotation with the other cans on the can rack. The FSD said that staff should not touch ready-to-eat food with contaminated gloves. During an interview on 1/16/25 at 9:35 A.M., the Director of Nursing said that nursing should date juices and nutritionally fortified supplemental shakes when they open them.

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NAME OF PROVIDER OR SUPPLIER Sherrill House		STREET ADDRESS, CITY, STATE, ZIP CODE 135 South Huntington Avenue Boston, MA 02130	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on observation, interview and record review, the facility failed to adhere to infection control standards of practice for one Resident (#23) out of a total sample of 34 residents. Specifically, for Resident #23 the facility failed to appropriately follow Enhanced Barrier Precautions (EBP: the use of protective gowns and gloves during high contact care activities that may provide opportunity for transmission of medication resistant organisms through staff hands and/or clothing), when providing high contact care for the Resident, increasing the risk of contamination and spreading infections to the Resident and other Residents within the facility. Findings include: Review of the facility policy titled Enhanced Barrier Precautions dated March 2024, indicated the following but not limited to: -EBP are indicated for residents with any of the following: Indwelling medical devices including central lines, urinary catheters, feeding tubes, and tracheostomies. -For residents for whom EBP are indicated, EBP is employed when performing the following high contact resident care activities. -Dressing, bathing/showering, transferring, hygiene, changing linens, changing briefs, device care or use of central line, urinary catheter, feeding tube, tracheostomy, wound care. Resident #23 was admitted to the facility in November 2024 with diagnoses including gastrostomy status, dysphagia oropharyngeal phase. Review of the Resident's Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #23 scored a 15 out of a possible 15 indicating he/she was cognitively intact. The MDS further indicated that the Resident had a peg tube (a feeding tube that's surgically inserted through the abdomen and into the stomach). Review of Resident #23's Nutrition care plan dated 12/4/24 indicated Resident #23 had a peg tube. On 1/14/25 at 10:33 A.M., the surveyor did not observe a signage for EBP on Resident #23's doorway. On 1/15/25 at 8:11 A.M., the surveyor did not observe a signage for EBP on Resident #23's doorway. During an interview on 1/15/25 at 11:19 A.M., Unit Manager #4 said the Resident was admitted to the facility with a peg tube and only receives flushes through the peg tube every six hours. Unit manager #4 said she was not sure if a resident with a peg tube needed to be on enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/25 at 12:09 P.M., Charge Nurse #3 said she was not sure if the Resident with a peg tube needed to be on enhanced barrier precautions. During an interview on 1/15/25 at 12:24 P.M., the Director of Nursing said all residents that have medical devices should be on enhanced barrier precaution and there should be a signage posted to indicate as such on the resident's doorway.