STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225506	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North End Rehabilitation and Healthcare Center	70 Fulton Street Boston, MA 02109

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 49880 Based on observations, interviews, record review and policy review, the facility failed to identify and assess the use of pillows underneath a fitted sheet, bilaterally, as a potential restraint for one Resident (#63) out of a total sample of 19 residents. Findings Include: Review of facility policy titled Use of Restraints, dated as revised April 2017, indicated the following: -Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. -1. Physical Restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. -6. Prior to placing a resident in restraints there shall be a pre-restraining assessment and review to determine the need for restraints. Resident #63 was admitted to the facility in September 2021 with diagnoses that include dementia, spinal stenosis, and anxiety disorder. Review of Resident #63's most recent Minimum Data Set (MDS) Assessment, dated 4/19/24 indicated he/she was unable to participate in the Brief Interview for Mental Status Exam and was assessed by staff as having severe cognitive impairment. On 5/21/24 at 7:58 A.M., the surveyor observed Resident #63 sleeping in bed with pillows tucked under his/her fitted sheet bilaterally. On 5/21/24 at 12:30 P.M., the surveyor observed Resident #63 in bed, pillows were tucked under his/her fitted sheet bilaterally. On 5/22/24 at 7:13 A.M., the surveyor observed Resident #63 sleeping in bed with pillows tucked under his/her fitted sheet bilaterally. (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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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/23/24 at 6:42 A.M., the surveyor observed Resident #63 sleeping in bed with pillows tucked under his/her fitted sheet bilaterally. Review of Resident #63's medical record failed to indicate a restraint assessment was completed to assess whether pillows tucked under the fitted sheet on his/her bed could be a restraint. Review of Resident #63's plan of care failed to indicate the use of pillows tucked into his/her fitted sheet. During an interview on 5/23/24 at 6:57 A.M., Certified Nursing Assistant (CNA) #1 said that she had worked overnight and took care of Resident #63. CNA #1 said that Resident #63 moves a lot in bed and the pillows tucked under the sheets prevent her from rolling out of the bed. During an observation and interview on 5/23/24 at 7:01 A.M., the Assistant Director of Nurses (ADON) observed the pillows under the fitted sheet and said that the pillows tucked into the sheets would be considered a restraint and Resident #63 was not assessed to have the use of a restraint. The ADON said that if staff are using any device that could be considered a restraint, an assessment would need to be completed. During an interview on 5/23/24 at 9:53 A.M., the Director of Nurses (DON) said that Resident #63 has not been assessed for the use of the pillows as a potential restraint and that staff have not been instructed to tuck pillows under the fitted sheet of Resident #63. The DON said that the pillows tucked under the fitted sheet could be considered a restraint.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on record review and interview, the facility failed to develop and implement care plans for one Resident (#57) out of a total of 19 sampled residents. Specifically, the facility failed to develop and implement a plan of care related to an implantable cardioverter defibrillator. Findings include: Review of the facility's policy Care of Implantable Cardioverter Defibrillator, undated, indicated: Overview: An implantable cardioverter defibrillator (ICD) is a small device placed in the chest that detects and corrects life-threatening irregular heart rhythms and can help the heart maintain a steady, stable rhythm. ICD's can deliver a defibrillating shock to attempt to correct the heart rhythm. Monitor: Monitor the resident for ICD failure by monitoring for signs and symptoms of arrhythmias. Monitor the resident for a defibrillating shock (ICD). If the ICD delivers a shock, encourage the resident to stay calm, find a safe place for the resident to assist or lie down, perform an assessment of the resident and notify the physician for further actions. Call emergency services and initiate CPR if indicated. The ICD battery will be monitored closely through the telephone or an internet connection. Documentation: For each resident with an ICD, document the resident's individualized needs and intervention in the care plan. For residents with an ICD, document the following in the medical record upon admission: The name, address and telephone number of the cardiologist, type of ICD, type of leads, manufacturer and model, serial number, date of implant. Resident #57 was admitted to the facility in [DATE] with diagnoses including end stage renal disease and chronic systolic heart failure. Review of Resident #57's hospital discharge paperwork indicated he/she had an ICD placed in [DATE]. Review of Resident #57's clinical record failed to indicate information related to Resident #57's ICD and failed to include a care plan with individualized interventions, methods or means for staff to monitor or identify his/her ICD. During an interview on [DATE] at 1:45 P.M., the Assistant Director of Nursing (ADON) said all information related to internal defibrillators should be included in the resident record. The ADON was not aware that Resident #57 had an internal defibrillator.

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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** 43807 Based on observations, record review, policy review and interviews, the facility failed to meet professional standards of nursing practice for two Residents (#18 and #3) out of a total sample of 19 Residents. Specifically, 1. For Resident #18, the facility failed to failed to address suicide threats in a timely manner. 2. For Resident #3 the facility failed to follow the recommendations from a physiatrist (a doctor who specializes in physical medicine and rehabilitation) for physical therapy and occupational therapy evaluations. Findings include: A review of the facility policy titled 'Suicide Threats' with a revision date of December 2007 indicated the following: -Resident suicide threats shall be taken seriously and addressed appropriately. -Staff shall report any resident threats of suicide immediately to the nurse supervisor/charge nurse. -A staff member shall remain with the resident until the nurse supervisor/charge nurse arrives to evaluate the resident. -After assessing the resident in more detail, the nurse supervisor/charge nurse shall notify the resident's attending physician and responsible party and shall seek further direction from the physician. -All nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the resident's behavior immediately. -As indicated, a psychiatric consultation or transfer for emergency psychiatric evaluation may be initiated. -If the resident remains in the facility, staff will monitor the resident's mood and behavior and update care plans accordingly, until a physician has determined that a risk of suicide does not appear to be present. -Staff shall document details of the situation objectively in the resident's medial record. 1. Resident #18 was admitted to the facility in December 2020 with diagnoses including major depressive disorder and psychotic disorder with delusions. A review of the most recent Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental (BIMS) score of 2 out of a possible 15, indicating severe cognitive impairment. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/24 at 8:03 A.M., the surveyor observed Resident #18 in bed, he/she was teary, rocking side to side in bed. The Resident told the surveyor he/she was going to kill himself/herself, the Resident said he/she was going to throw himself/herself out of the window and no one could stop him/her, the Resident said he/she was a nobody. During an interview on 5/21/24 at 8:09 A.M., the surveyor told the Unit Manager that the Resident was making suicidal threats. The Unit Manager said that the Resident makes suicidal threats all the time, she told the surveyor that the Resident was not going to kill himself/herself. The unit manager walked away and continued to pass breakfast trays. During an interview on 5/21/24 at 12:24 P.M., the Social Workers, Director of Nurses and Assistant Director of Nurses said the Unit Manager had not communicated to them about any concerns with Resident #18. They said that staff are expected to immediately put any resident who voices suicidal threats on one-to-one supervision while they notify the Director of Nurses. The Director of Nurses said the Resident is expected to remain on one-to-one supervision until a Psychiatric Nurse Practitioner assesses them and determines the risk of suicide does not appear to be present. The Director of Nurses said the Resident has had a lot of losses recently. She said the Unit Manger did not address the Resident's suicidal threats appropriately. 49880 2. Resident #2 was admitted to the facility in September 2021 with diagnoses that include Alzheimer's disease, insomnia, and history of falling. Review of Resident #2's Minimum Data Set (MDS) Assessment, dated 4/3/24, indicated a Brief Interview for Mental Status (BIMS) score of 11 out of a possible 15, indicating that Resident #2 has moderate cognitive impairment. Review of Resident #2's Physiatrist's progress note, dated 5/12/24, indicated, PT (physical therapy)/OT (occupational therapy) consult for ADLs (activities of daily living), bed mobility, transfers and ambulation training, to assess the candidacy for another bout of therapy, and to verify if right foot eversion is affecting gait. [Resident] was seen and examined at bedside this morning. IDT (interdisciplinary team) asked us to see this patient due to ongoing functional decline. Review of the medical record indicated that the most recent therapy evaluation was completed in January 2024. The medical record failed to indicate that the physiatrist's recommendations were acted upon for PT and OT consults. During an interview on 5/23/24 at 9:48 A.M., the Director of Nurses (DON) said that the IDT had asked physiatry services to see Resident #2 due to an ongoing functional decline. The DON said that usually the physiatrist will relay orders or recommendations to the nursing staff to communicate with Rehab staff. The medical record was reviewed with the DON and she said the request for therapy evaluations was not communicated to rehab, and that Resident #2 is not on rehabilitation services at this time.

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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. 49880 Based on observation, record review and interview the facility failed to maintain accurate medical records for one Resident (#41) out of a total sample of 19 residents. Specifically, the facility inaccurately documented the changing and replacement of a suprapubic catheter. Findings Include: Resident #41 was admitted to the facility in March 2022 with diagnoses that include muscle wasting and atrophy, benign prostate hyperplasia and retention of urine. Review of Resident #41's most recent Minimum Data Set (MDS) Assessment, dated 5/1/24, indicated a Brief Interview for Mental Status (BIMS) score of 4 out of a possible 15 indicating that the Resident has severe cognitive impairment. The MDS further indicated the presence of an indwelling urinary catheter. On 5/23/24 at 6:46 A.M., the surveyor observed a urinary drainage bag hanging on Resident #41's bed frame. Review of Resident #41's physician's orders indicated an order, dated 2/6/23, to replace the suprapubic catheter 14 fr (French), 10 ml (milliliters) balloon, monthly on the 6th of every month. Review of Resident #41's care plan indicated, I have a suprapubic catheter: for urinary retention, dated 4/5/22. Review of Resident #41's Treatment Administration Record indicated that the suprapubic catheter was documented as replaced 23 days in February 2024 and three days in March 2024. Review of Resident #41's progress notes indicated the following: -A progress note dated 4/1/24, Resident returned back from Mass General for sp (suprapubic) blockage. New sp cath (catheter) installed and patent. 2500 (ml) of urine obtained from resident at the hospital. -A progress note dated 4/8/24 The Resident was scheduled for urology appointment to have [suprapubic catheter] changed. Next appointment is scheduled for May 6th at 11:30 A.M. During an interview on 5/23/24 at 9:36 A.M., the Director of Nurses (DON) said that the suprapubic catheter was not changed 23 days in February and that the documentation was inaccurate. She said that the staff at the facility do not change suprapubic catheters as it is not a procedure performed in the facility. The DON said that the Resident goes out to urology for catheter replacements.