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	04/30/2026

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

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician orders without errors for two of three residents (Resident #89 and #23) observed to receive medication during the survey. This resulted in a facility medication error rate of 28%.Findings include: Review of the facility's policy and procedure titled Administering Medications dated 2001, indicated, but was not limited to:Medications are administered in accordance with prescribed orders, including any required time frames.Medications are administered within one (1) hour of their prescribed time, unless the otherwise specified (for example, before and after meal orders).On 4/29/26 between 9:52 A.M. and 10:25 A.M., the surveyor observed 25 opportunities of medication administration by two nurses (Nurse #1 and Nurse #2) and 7 of the 25 medications were not administered in accordance with physician's orders, resulting in a medication error rate of 28%.1.On 4/29/26 at 10:06 A.M., the surveyor observed Nurse #1 administer the following medications to Resident #23:Gabapentin 600 mg tabletDiltiazem 300 mg capsuleClopidogrel Bisulfate 75 mg tabletColace 100 mg capsuleBrimonidine Tartrate Ophthalmic Solution 0.2 %Review of Resident #23's physician's orders and medication administration record dated April 2026 indicated:Gabapentin oral tablet 600 mg. Give 1 tablet by mouth three times a day for neuropathy. To be given at 8 AM, 1 PM and 5 PM.Diltiazem capsule extended release 24 hour 300 mg. Give 1 capsule by mouth one time a day related to essential (primary) hypertension. To be given at 8 AM.Clopidogrel Bisulfate tablet 75 mg. Give 1 tablet by mouth one time a day related to cerebral infarction, unspecified. To be given at 8 AM.Colace capsule 100 mg (Docusate Sodium). Give 1 capsule by mouth two times a day for constipation. To be given at 8AM and 5 PM.Brimonidine Tartrate Ophthalmic Solution 0.2 %. Instill 1 drop in both eyes two times a day for ophthalmic agents. To be given at 8 AM and 8 PM.During an interview with Nurse #1 on 4/29/26 at approximately 10:25 A.M., she said some of the medications she administered to Resident #23 were scheduled to be given at 8:00 A.M. and that she administered them late. Nurse #1 said medications are required to be given within one hour of the time prescribed by the physician's order. Nurse #1 said she often has difficulty administering all the residents' medications on time because of how many are ordered to be given at 8:00 A.M.2. On 4/29/26 at 9:52 A.M., the surveyor observed Nurse #2 administered the following medications to Resident #89:Eloquis 2.5 milligrams (mg)Torsemide 2.5 mgReview of Resident #89's physician's orders and medication administration record dated April 2026 indicated:Eliquis oral tablet 2.5 mg (Apixaban). Give 2.5 mg by mouth two times a day to be given at 8 AM and 8 PM.Torsemide tablet 10 mg tablet. Give 0.5 tablet by mouth two times a day indicated o be given at 8 AM and 4 PM.During an interview with Nurse #2 on 4/29/26 at 10:03 A.M., she said some of the medications she administered to Resident #89 were scheduled to be given at 8:00 A.M., and that she administered them late. Nurse #2 said medications are required to be given within one hour of the time prescribed by the physician's order. Nurse #2 said she often has difficulty administering all the residents' medications on time because of how many are ordered to be given at 8:00 A.M.During an interview with the Director of Nursing at approximately 11:00 A.M. on 4/29/26, she said nursing staff are required to administer medications within one hour of the time prescribed in the physician's order.

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 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** Based on observation, record reviews and interviews, the facility failed for one Resident (#69), out of 20 sampled residents, to provide standards of quality nursing practice related to diabetes mellitus management. Specifically, for Resident #69 the nursing facility staff failed to obtain and record Resident #69's blood sugar in accordance with the physician's orders.Findings include: Review of [NAME], Manual of Nursing Practice 11th edition, dated 2019 indicated the following: - The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. 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. Review of the facility's policy titled Nursing Care of the Older Adult with Diabetes Mellitus revision date November 2020 indicates: Purpose to provide and overview of diabetes in the older adult, its symptoms and complications, and the principles of glucose monitoring. For further diabetes education and guidelines, refer to the provider orders and instructions as well as the American Diabetes Association, Standards of medical Care in Diabetes. Glycemic Targets, 4. The provider will order the frequency of glucose monitoring and establish appropriate glycemic targets for individual residents. Resident #69 was admitted to the facility in August 2024 and has diagnoses that include dementia, acquired right leg amputation and type 2 diabetes mellitus.Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #69 scored 14 out 15 on the Brief Interview for Mental Status exam, indicating he/she is cognitively intact. Further review of the MDS indicated Resident #69 has been administered insulin during the last seven days.During an observation on 4/28/26 at 10:52 A.M., Resident #69 was sitting up in a wheelchair. Resident #69's left leg was observed wrapped in a dressing and his/her right leg was observed to be amputated. Resident #69 greeted surveyor but he/she did not participate in answering any questions about his/her care. Review of Resident #69's physician's orders indicated the following: -Check FSBS (finger stick blood sugar, a method of measuring blood glucose levels) two times a day, order date 9/20/24.Review of Resident #69's Medication Administration Record (MAR) dated 4/1/26 through 4/29/26 indicated the following: Check FSBS two times a day for DMT2 (diabetes mellitus type two) start date 9/20/24, 0600 (6:00 A.M.). The following dates were blank on the MAR; 4/6/26, 4/7/26, 4/19/26, 4/21/26, 4/22/26, 4/25,26, 4/27/26, and 4/28/26 for a total of 9 out of 29 6:00 A.M., FSBS checks.During an interview on 4/30/26 at 6:56 A.M., Nurse #3 said Resident #69 has diabetes and accepts having blood sugar checks. Nurse #3 said Resident #69 has blood sugar checks two times a day to manage his/her diabetes. Nurse #3 said he obtains the 6:00 A.M., blood sugars and passes the results to the oncoming nurse. Nurse #3 said he does not always enter the blood sugar results in the clinical record. Nurse #3 said Resident #69's blood sugar results should be available for the doctor or nurse practitioner to see in the record. Nurse #3 said if blood sugars are not on the MAR, you cannot validate the blood sugar monitoring was completed. During an interview on 4/30/26 at 7:09 A.M., the Assistant Director of Nursing (ADON) said blood sugars are according to the physician's orders. The ADON said the blood sugars results are expected to be in the electronic MAR, and available for the nurse practitioner and doctor to review. The ADON said the night nurse would be responsible for the 6:00 A.M. blood sugar checks and she would expect the blood sugars checks to be completed as ordered.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed for one Resident (#10), out of a total sample of 20 residents to provide quality standards of nursing care. Specifically, the facility staff failed to identify a large discoloration consistent with a bruise on Resident #10's right forehead.^ Findings include: Review of the facility's policy, titled Falls-Clinical Protocol revision date September 2012 indicated Monitoring and Follow Up. Staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. A. ?Delayed complications such as late fractures and major bruising may occur hours or several days after a fall'Resident #10 was admitted to the facility in August 2024 and has diagnoses that include but are not limited to chronic obstructive pulmonary disease, and unspecified dementia.Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #10 scored a 5 out of 15 on the Brief Interview for Mental Status exam, indicating he/she has severe cognitive impairment. Further, the MDS indicated Resident #10 requires partial to moderate assistance with daily care including bathing, and dressing. During an observation and interview on 4/28/26 at 7:35 A.M., Resident #10 was observed with a discolored area that was dark purple/blue/yellowish in color on the right side of his/her forehead. The discolored area was consistent with a bruise and was approximately the size of a silver dollar. Resident #10 said he/she fell. During an observation on 4/28/26 at 9:49 A.M., Resident #10 was in the hallway outside of his/her room, yelling and screaming at staff nearby. Resident #10 was observed with an area of discoloration visible on his/her right forehead/temple area, while staff were interacting with him/her. On 4/28/26 the following observations were made: -At 10:57 A.M., Resident #10 was walking in the hallway and said to another resident that he/she just came from the hairdresser. Resident #10 was observed with a large, discolored area on his/her right forehead.-At 11:27 A.M., Resident #10 was walking with activity staff, who was standing on his/her right side, the same side as the area on his/her forehead. -At 11:48 A.M., Resident #10 was in the dining room with staff present eating his/her lunch. The discoloration on his/her forehead was visible.-At 3:51 P.M. Resident #10 observed sitting on the side of his/her bed with a walker in front of him/her. Resident #10 said he/she got the bruise from all the water in the bathroom and said he/she fell.Review of Resident #10's clinical record indicated the following: A weekly skin check dated 4/22/26 indicated a skin tear left outer elbow. A progress note dated 4/22/26 ?At 4:00 am (sic) patent yelled for help. This nurse and the CNA (certified nursing assistant) got to the room and found the patient on the floor near his/her closet.Review of Resident #10's care plans indicated the following:-Resident #10 had an actual fall r/t (related to) unsteady gait, s/p (status post) fall on 4/22/26. The care plan did not indicate Resident #10 sustained a right forehead bruise. -I have an ADL (activities of daily living) Self-care performance deficit due to impaired balance, cognitive decline dated 8/27/24. An intervention dated 8/27/24 indicated Provide skin inspection daily during care. Observe for redness, open areas, cuts, bruises, etc. and report changes to the Nurse.-I am at risk for impaired skin integrity due to incontinence, history of lower leg vascular ulcers, frequent falls dated 9/9/25, Interventions included: Notify nurse immediately of any skin changes, redness, blisters, bruises, discoloration, etc. noted during care dated 9/9/25.Review of the progress notes from 4/22/26 through 4/27/26 failed to indicate Resident #10 was identified by staff with an alteration on his/her right forehead.Review of the physician's orders failed to indicate any order to monitor any area on Resident #10's right forehead. During an interview and observation on 4/28/26 at 4:34 P.M., Nurse #2 said she is on shift from 7:00 A.M, through 7:00 P.M., today. Nurse #2 said she did not know anything about a bruise on Resident #10's right side of his/her forehead. Nurse #2 and the surveyor went to Resident #10's room and Resident #10 let Nurse #2 look at his/her forehead. Nurse #2 said the area was a bruise with faded yellow edges indicating it was fading. Nurse #2 said Resident #10 fell recently and got a skin (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tear on his/her forearm. Nurse #2 said she had not noticed the area until the surveyor brought it up to her, and that no staff brought the bruise to her attention. Nurse #2 said staff were with Resident #10 today and no one mentioned the area. Nurse #2 said when a resident has a change like a bruise the staff are to report it to the nurse. Nurse #2 said the doctor or nurse practitioner are notified of bruises, and orders are put in place to monitor the area. Nurse #2 said the nursing staff would document the bruise in the clinical record if it had been identified. During an interview on 4/28/26 at 4:47 P.M., the Director of Nursing (DON) said Resident #10 had a fall recently and was placed on neuro checks. The DON said she would expect staff to identify and report any new areas on a resident including a bruise. The DON said she spoke to the Resident after the fall and implemented neuro checks because the Resident said he/she bumped his/her head. The DON said there was no documentation in the clinical record that staff identified the bruise on the resident's right temple.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, records review and interview the facility failed to ensure for one Resident (#46) out of total sample of 20 residents, was provided professional standards of care. Specifically, the facility failed to implement having Resident #46's suprapubic catheter changed in accordance with the urology medical plan. Findings include: Resident #46 was admitted to the facility in March 2022 and has diagnoses that include but are not limited to, other obstructive and reflux uropathy and benign prostatic hyperplasia with lower urinary tract symptoms. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #46 scored a 7 out of 15 on the Brief Interview for Mental Status exam, indicating he/she had severely impaired cognition. Further review of the MDS indicated he/she has an indwelling catheter. Review of the comprehensive MDS dated [DATE], indicated Resident #46 triggered for use of an indwelling catheter. On 4/28/26 9:14 A.M., Resident #46 was observed in the hallway looking out the window. A urine collection bag was covered under his/her wheelchair. During an observation and interview on 4/29/26 at 8:20 A.M., Resident #46 was sitting up in a wheelchair with his/her breakfast tray. A stale odor of urine was detected around the Resident, and the tube from the suprapubic catheter was dark purple. The area on top of the collection bag was filled with white/brown substance and debris. Resident #46 said he/she did go out to urology and said he/she could not recall when. Review of Resident #46's care plan indicated the following: I have a suprapubic urinary catheter due to chronic urinary retention dated 12/28/22. Interventions included but not limited to, change catheter as clinically indicated and as ordered. Review of Resident #46's physician's orders indicated the following:-replace suprapubic catheter (SPT) 14 Fr (French) (tube size) and 10 cc balloon monthly. as needed, order date 5/23/24. Review of the document with the encounter date 11/23/25, titled progress note indicated drainage bag tubing and foley catheter noted to be purple with foul odor on arrival. While maintaining sterile technique, existing SPT catheter gently removed. Then a 14 fr. (French) silastic was gently inserted into the bladder. 10 ml sterile water placed in catheter balloon. Patient tolerated the procedure well. He/she will return in 4 to 6 weeks for next SPT change. Review of the urology office visit document dated 4/1/26, indicated he/she has an indwelling #14-French suprapubic catheter. Urine in the bag and tubing is extremely cloudy and dark. Further, review of the of the urology visit document indicated the suprapubic catheter gets exchanged at the Nursing facility. Review of the medical record indicated there were no further provider progress notes provided to indicate Resident #46 had the suprapubic catheter changed in 4 to 6 weeks from 11/23/25. Further, review of the medical record indicated Resident #46's subpubic catheter was changed on 11/23/25 and had not been changed in over 5 months. Review of the Treatment Administration Record (TAR) for 1/1/26-1/31/26, 2/1/26-2/28/26, 3/1/26-3/31/26, 4/1/26-4/30/26, failed to indicate the suprapubic catheter was changed. During an interview on 4/29/26 at 11:55 A.M. Nurse #2 said Resident #46's plan for the suprapubic catheter is to monitor the site. Nurse #2 said that the Resident goes out to have the catheter changed. Nurse #2 said the facility does not change suprapubic catheters at the facility. Nurse #2 did not know when the suprapubic catheter was changed but said the Resident did go to urology the beginning of the month (April). During an interview on 4/29/26 at 1:48 P.M., Nurse Practitioner (NP) #1 said a suprapubic catheter should be changed about the six to eight weeks mark, or in some cases longer, or if it is clogged or denatured (the process of losing its original structure or function). NP #1 said she is not aware if Resident #46 had gone out to have the suprapubic catheter changed, and it would be her expectation to have it changed in house (facility). NP #1 reviewed the physician's order for the change and said it does not provide clear instructions for changing the SPT monthly or prn (as needed). NP #1 reviewed the provider visit notes dated 11/23/25 and 4/1/26 and said it appeared the tube was not exchanged and should have been changed since 11/23/25. NP #1 said by not having a (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan to change the suprapubic catheter could put the Resident as risk for infection or change in condition. NP #1 said she saw the resident on Monday or Tuesday this week and did not look at the tube. During an interview on 4/29/26 at 3:06 P.M., the Director of Nursing (DON) said the nurses at the facility are not currently changing suprapubic catheters, and that a resident would need to go out to a clinic, urology or interventional radiology to have it exchanged. The DON reviewed the 4/1/26 urology consult that indicated the suprapubic catheter gets changed at the facility and said they are not changing suprapubic catheters at the facility and there was confusion on the urology provider's part. The DON said the physician's order is meant to be prn (as needed) and could not explain why there was an order for changing a SPT, when they do not have a policy to provide that treatment. During an interview on 4/29/26 at 4:54 P.M., and 4/30/26 at 12:38 P.M., the DON said there was no further information to support that Resident #46 had his/her suprapubic catheter changed since 11/23/25. The DON said that she will need to clarify with the urologist and nurse practitioner for a plan of care to change Resident #46's suprapubic catheter.