

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 225506	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2020
NAME OF PROVIDER OF SUPPLIER NORTH END REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 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 0880 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on staff observation, staff interview, and Center for Disease Control Guidelines, the facility failed to ensure that staff utilized personal protective equipment (PPE) according to transmission-based precautions protocol as required to prevent possible spread of COVID-19 in the facility. Findings include: Per CDC Guidelines, the facility should perform appropriate screening, restriction and education of visitors: Signage should be posted at facility entrances for screening and restrictions. Visitors entering a Long Term Care (LTC) facility are required to be screened by the facility staff for signs and symptoms of COVID-19 (should include a temperature-taken by a facility staff member and questions related to the signs and symptom of COVID-19), are instructed to perform hand hygiene and offered Personal Protective Equipment (PPE, e.g., facemask) if the visitor entered without one. No visitor is allowed entry into the LTC facility without being screened for the above by a facility staff member and without wearing a mask. The following observations were made by the surveyor on 6/23/20: At 12: 10 P.M. the surveyor entered the building . The surveyor introduced and identified himself to the receptionist and asked to speak with the Administrator or the Director of Nursing. The surveyor waited in the lobby area for approximately 4 minutes for the Administrator to arrive and greet the surveyor. The receptionist made no attempt to screen or obtain the temperature of the surveyor. The administrator was informed of this omission upon arrival to the Administrators office shortly after .		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE		(X6) DATE

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.