STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225437	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarwood Rehabilitation & Healthcare Center	150 Lincoln Street Needham, MA 02492

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36542 Based on interview and record review, the facility failed to ensure advanced directives were reviewed and followed-up on for one Resident (#44), out of 24 sampled residents. Specifically, the facility failed to ensure the wishes for Do Not Resuscitate (DNR) were pursued as legally allowed for Resident #44. Findings include: Review of the facility's policy titled Advanced Directives, dates as revised in [DATE], indicated the following: -Do Not Resuscitate (DNR)- indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used. -If the resident or representative indicates that he/she has not established advanced directives, the facility staff will offer assistance in establishing advanced directives. Resident #44 was admitted to the facility in February 2024 with diagnoses including a history of a stroke and dementia. Review of the Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #44 scored a 0 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Review of the medical record for Resident #44 included the following: -Decree and Order of Appointment of Guardianship for an incapacitated person indicating three family members were co-guardians. A post-it note on the guardianship paperwork indicated Guardianship in place, guardian does NOT have authorization for Advanced Directives, no MOLST (Massachusetts Medical Orders for Life-Sustaining Treatment), Resident is a Full Code -a MOLST form signed by two physicians in [DATE] indicating Resident #44 was a DNR. The title of the MOLST in the electronic medical record indicated *Void* not valid-no auth (authorization) on guardianship and signed by unknown (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the electronic medical record Documents section included Pre-Admission Hospital Documentation with an additional note indicating enclosed MOLST is VOID During an interview on [DATE] at 10:30 A.M., the brother of Resident #44 said he was the guardian along with his spouse and child. He said Resident #44 had a history of being on hospice service and had graduated from hospice services but had continued to have advanced directives of Do Not Resuscitate. He said he believed he had discussed this with the facility and the previous living residence had sent over the DNR form. During an interview on [DATE] at 4:30 P.M., Social Worker #1 said she was not the regular Social Worker for Resident #44. She said Social Worker #2 was the assigned Social Worker but was not available. She said in Massachusetts, when a family member has been appointed the legal guardian, they have the authority to make decisions regarding code status (full code versus DNR). She said she believed the three co-guardians of Resident #44 had a conflict regarding the code status and that was why Resident #44 was a full code. She said she thought Social Worker #2 had reviewed this and the court had been petitioned to expand the guardianship to include advanced directives. She said she would review the medical record and any information from Social Worker #2 for documentation to support that the wishes for changes to the code status had been pursued. Review of the Social Service Progress Notes indicated the following: [DATE]: Resident #44 is a full code status as the guardianship does not include authorization for advanced directives. [DATE]: Social Worker inquired about treatment plan for use of antipsychotics. [DATE]: Social Worker spoke with guardian about extending the authority to admit to a nursing home and the court approval for the antipsychotic treatment plan. [DATE]: court appointed antipsychotic monitor missed court hearing on [DATE]. Social Worker referred case to the facility attorney to assist with treatment plan approval. [DATE]: new medical certificate sent for treatment plan court date of [DATE]. The medical record did not indicate the Social Worker had reviewed what, if any, legal pursuits would be needed to change the Resident's code status. During an interview on [DATE] at 10:30 A.M., Social Worker #1 said she was unable to locate any documentation to indicate there was a conflict regarding code status between the guardians. She said she thought the family was actively pursuing expanding the guardianship to include advanced directives. During an interview on [DATE] at 10:15 A.M., Social Worker #1 said she contacted the family's attorney who had been working on the expansion of guardianship for intent to admit to a nursing home and the antipsychotic treatment plan and the attorney said they were not working on the expansion of guardianship to include advanced directives. She said she did not know why the family thought Resident was a DNR as Social Worker #2 had checked a box indicating advanced directives had been reviewed with the family on [DATE]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:55 A.M., Social Worker #1 said she had reviewed all hospital admission paperwork, guardianship paperwork, and progress notes and could not see any information to indicate the facility had pursued changing the code status of Resident #44, as indicated by the wishes of the family.

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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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41106 Based on record review, interview, and policy review, the facility failed to follow professional standards of practice for two Residents (#261 and #211), out of a total sample of 23 residents. Specifically, the facility failed: 1. For Resident #261, to monitor the Resident's right upper extremity Peripherally Inserted Central Catheter (PICC-a thin flexible tube inserted into a vein in the upper arm and guided into a large vein above the right side of the heart called the superior vena cava (SVC) insertion site for signs/symptoms of infection in accordance with the physician's order; and 2. For Resident #211, to ensure the Resident's medications that should not be crushed were administered as whole pills in accordance with the physician's order, pharmacy label, and medication administration guidelines. Findings include: 1. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, Advisory Ruling Number 9324, dated as revised July 10, 2002, indicated: -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers 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 Central Venous Catheter Care and Dressing Changes, revised March 2022, indicated but was not limited to the following: -Apply sterile dressing a. Center the dressing over the insertion site. b. Starting at the catheter, smooth dressing outward toward the edges to remove air. c. Press down on the edges of the dressing while removing the paper around edges of the dressing. d. Sterile tape from the kit may be used to secure the edges if needed. The tape should not cover the insertion site. Resident #261 was admitted to the facility in July 2024 with diagnoses which included osteomyelitis (infection of the bone) of the lumbar vertebra and pneumonia. Review of the Physician's Orders indicated but were not limited to the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Intravenous (IV): Right arm double lumen PICC. Change transparent dressing on admission and then every seven days; caps to be changed during dressing change. Effective date 7/17/2024. -IV: Assess IV site for unusual redness, drainage, skin, irritation, pain at the site, patient confusion, and patient diaphoresis (excessive sweating), observe for tenderness or induration when gently palpating the vein pathway above the IV site, every shift document in progress note. Effective 7/17/2024. -IV: Assess that the IV catheter is secured well and does not slide around in the vein or become dislodged, the dressing is adhered with no moisture accumulation underneath it every shift. Document in progress notes. Effective 7/17/2024. Review of the Medication Administration Record (MAR) indicated the above listed orders were completed every shift, 19 out of 19 opportunities as ordered by the physician 7/18/2024 through 7/24/2024. On 7/23/24 at 11:34 A.M., the surveyor observed Resident #261's right arm PICC dressing, dated 7/18, which had a large white gauze under the clear dressing completely obscuring the PICC line insertion site and skin. The insertion site was further obscured by the dated tape over the bottom of the dressing. On 7/24/24 at 5:00 P.M., the surveyor observed Resident #261's right arm PICC line dressing, dated 7/18, with the white gauze under the clear dressing completely obscuring the PICC line insertion site or skin. The insertion site was further obscured by the dated tape over the bottom of the dressing. During an interview on 7/24/24 at 5:15 P.M., Unit Manager (UM) #1 said there should be a clear dressing over the PICC line so they can monitor the site every shift for redness and swelling. On 7/24/24 at 5:17 P.M., the Surveyor, Nurse #1, and UM #1 observed Resident #261's PICC line dressing and observed the gauze under the clear dressing and the tape dated 7/18 at the base of the PICC line dressing. During an interview on 7/24/24 at 5:19 P.M., UM #1 said the gauze is covering the insertion site and you need to be able to see the site to monitor for signs of infection. UM #1 said she was not aware the nurses had been signing off on the MAR that they were monitoring the site since Resident #231's admission. During an interview on 7/24/24 at 5:20 P.M., Nurse #1 said she observed the insertion site today for signs and symptoms when she flushed the PICC line. During an interview on 7/24/24 at 5:31 P.M., the Assistant Director of Nursing (ADON) said she would expect the dressing to be transparent to view the PICC insertion site. The surveyor informed the ADON that Resident #231's PICC dressing had a white gauze under the transparent dressing and the insertion site could not be visualized to perform the assessments as ordered by the physician. The ADON said she was made aware the PICC dressing had a gauze under the clear dressing, and it will need to be changed. 48084 (continued on next page)

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	225437	A. Building B. Wing	07/26/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the facility's policy titled Administering Medications, dated as last revised April 2019, indicated but was not limited to the following: -Medications are administered in a safe and timely manner, and as prescribed. -Medications are administered in accordance with prescriber orders. -The individual administering the medication check the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. -Each nurses' station has a current Physician Desk Reference (PDR) and/or access to another medication reference. Review of the facility's policy titled Preparation and General Guidelines, dated November 2021, indicated but was not limited to the following: -An individualized approach should be used when altering dosage forms by crushing or opening capsules. -An order to crush medications may be required or preferred in accordance with State regulation of facility preference. -Orders to crush medications should not be applied to medications which, if crushed, present a risk to the resident. For example: long acting or Enteric Coated forms should not be crushed; an alternative should be sought. -The instructions for crushing medications should be included on the resident's orders and the medication administration record (MAR/eMAR) so all personnel administering medications are aware of this need. On 7/24/24 at 9:20 A.M., the surveyor observed Nurse #1 prepare nine morning medications for Resident #211, eight of which were to be administered by mouth and one was a topical patch: a. Ferrous Sulfate 325 milligrams (mg) (iron supplement) b. Acidophilus with Pectin capsule (probiotic with soluble fiber additive) c. Loratadine 10 mg (allergies) d. Acetaminophen 500 mg (2 tablets) (pain relief) e. Alfuzosin HCL ER (extended release) 10 mg (long acting for enlarged prostate) f. Eliquis 2.5 mg (2 tablets) (anticoagulant) g. Metoprolol Succinate ER 25 mg (long acting for blood pressure) (continued on next page)

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	225437	A. Building B. Wing	07/26/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h. Rosuvastatin 10 mg (treat high cholesterol) i. Lidoderm 4% Pain Patch (pain) -Seven pills/tablets were put into a medication cup and one capsule was put into a separate cup. -The seven pills/tablets were all crushed together, and the powder mixed with applesauce. -The one capsule was opened, and the contents mixed with the applesauce. Review of the [NAME] Drug Book, 19th edition, indicated the following: -Ferrous Sulfate tablet should be taken with a full glass of water or juice and tablets should not be crushed or chewed. -Alfuzosin was an extended-release tablet and should not be crushed. -Metoprolol Succinate was an extended-release tablet and should not be crushed. Review of the Physician's Orders to reconcile the medications ordered versus the medications administered indicated the following: -Ferrous Sulfate 325 mg tablet was ordered but was administered crushed. -Alfuzosin HCL ER 10 mg was ordered but was administered crushed. -Metoprolol Succinate ER 25 mg was ordered but was administered crushed. Review of the medication cards used by the nurse to pour the Alfuzosin HCL ER and Metoprolol Succinate ER indicated a green sticker from the pharmacy was on the card and it read SWALLOW WHOLE DO NOT CRUSH OR CHEW. During an interview on 7/24/24 at 9:25 A.M., Nurse #1 said she crushed all the medications except the Acidophilus, she said she opened that capsule and mixed all the medications with applesauce. During an interview on 7/24/24 at 1:35 P.M., Nurse #1 said she thought Ferrous Sulfate could be crushed and it was only the Slow FE (ferrous sulfate) that could not be crushed. Additionally, she said the Alfuzosin and Metoprolol Succinate are both extended release and say not to crush them, so she should not have crushed those medications, but Resident #211 had been having trouble swallowing so she had to crush the medications. During an interview on 7/25/24 at 10:20 A.M., UM #1 said she thought Ferrous Sulfate could be crushed. UM #1 said the Alfuzosin and Metoprolol Succinate should not have been crushed. During an interview on 7/25/24 at 3:00 P.M., the ADON said the Ferrous Sulfate, Alfuzosin, and Metoprolol Succinate should not be crushed. She said those medications should be administered whole in applesauce or pudding or they would need to obtain an order for a different medication. (continued on next page)

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	225437	A. Building B. Wing	07/26/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Refer to F759

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	225437	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 48084 Based on interview and record review, the facility failed to ensure staff implemented dialysis care and services consistent with professional standards of practice for one Resident (#102), out of 24 sampled residents. Specifically, the facility failed for Resident #102, to provide ongoing communication between the nursing facility and dialysis facility. Findings include: Review of the facility's policy titled Dialysis Communication, undated, indicated but was not limited to the following: -The facility and dialysis center will establish a communication and reporting mechanism to promote situational awareness between both facilities. -Routine communication of relevant information will be provided by the facility to the dialysis center. -The facility and dialysis center will determine a method to exchange written information between the centers on dialysis days. Examples of communication methods may include but are not limited to forms, binders, books, and copies of medical records. -Examples of information that may be communicated between the facilities include: a face-sheet, hemodialysis communication form (or equivalent), Physician orders, laboratory results, weight records, and other records deemed appropriate. -The dialysis center will communicate relevant information to the facility upon the resident's return to the facility. -Clarification, questions, or need for additional information to or from the dialysis center may be communicated via telephone. Review of the Long-Term Care Facility Coordination Agreement, dated 5/12/2015, indicated but was not limited to the following: -Coordination and Communication: Both parties shall ensure there is coordination of care and communication between Long-Term Care (LTC) Facility and the End-Stage Renal Disease (ESRD) Facility. -Documentation of Coordination: Both parties shall maintain documented evidence of care coordination and communication between the LTC facility and ESRD facility. Resident #102 was admitted to the facility in May 2024 with diagnoses which included ESRD and dependence on renal dialysis. (continued on next page)

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	225437	A. Building B. Wing	07/26/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS) assessment, dated 5/23/24, indicated Resident #102 was cognitively intact as evidenced by a score of 12 out of 15 on the Brief Interview for Mental Status (BIMS) and he/she received dialysis services. Review of the Comprehensive Care Plan indicated Resident #102 required interpreter services because their primary language was not English. Review of the Dialysis Communication Book indicated but was not limited to the following: -Resident #102 had dialysis three times a week. -Face sheet, Advanced Directives and Physician Orders from May 2024. -Blank Copies of the Dialysis/Observation Communication Form (only page 1 of 3). May 2024: of six treatment dates, the following information was in the binder: -5/22/24 the three-page communication form was incomplete; a recommendation was made and implemented. -5/27/24 the three-page communication form was blank except for a weight in the top right corner. June 2024: of 12 treatment dates, the following information was in the binder: -6/3/24 the three-page communication form was filled out by the LTC facility with no return documentation from the dialysis facility. -6/19/24 the three-page communication form was filled out by the LTC facility with no return documentation from the dialysis facility. -6/26/24 the three-page communication form was not in the binder; only page 1 of 3 was in the binder and it form was filled out by the LTC facility with no return documentation from the dialysis facility. July 2024: of 11 treatment dates, the following information was in the binder: -7/8/24 lab results print out from the ESRD facility; a recommendation was made and implemented. -7/24/24 the three-page communication form was not in the binder; only page 1 of 3 was in the binder and it form was filled out by the LTC facility with no return documentation from the dialysis facility. Further review of the binder failed to indicate ongoing written communication between the LTC and dialysis facility to coordinate care. Review of the weight record indicated post-dialysis weights were documented 17 of 29 times, or 59% of the time. (continued on next page)

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	225437	A. Building B. Wing	07/26/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Nursing Progress Notes failed to indicate ongoing communication between the LTC facility and the dialysis facility regarding the treatments. Further review of the progress notes indicated two progress notes noting communication between the LTC facility and the ESRD facility had occurred. During an interview on 7/25/24 at 10:21 A.M., Unit Manager (UM) #1 said the Dialysis Communication Book is supposed to go with Resident #102 for every treatment. She said the nurses should be completing the first page and the dialysis center should be documenting on page 2, the post treatment report. UM #1 said the sheet doesn't always come back or weights are just on a post it/sticky note. She said if he/she does not come back with the sheet filled out staff should be calling to get report and the weight and documenting. She said all communication forms should be in the binder and did not know why it was missing so many sheets. During an interview on 7/25/24 at 2:04 P.M., Nurse #2 said the nurses are supposed to fill out the communication sheet everyday Resident #102 has a treatment, and the center is supposed to send the report back. He said the dialysis center is terrible with return communication and it is very inconsistent. He said if they even send a weight back, it's often on a post-it note and there is no report. He said he does not usually work the evening shift when Resident #102 returns, but said if the report didn't come back, then the nurse should be calling for the report and writing a progress note. He said he has never spoken to the dialysis center. During an interview on 7/25/24 at 3:00 P.M., the Assistant Director of Nurses (ADON) said they send the communication book to the dialysis center, and they do not always return it. She said they call us if there is a problem, but the daily communication is not good. She said she was unsure if the nurses were sending the communication sheets filled out and the dialysis center was taking them out or where the breakdown was. She said the weights are often just on a sticky note. She said the three-page communication sheet is a corporate form and it should probably be revised as it is too confusing and too long. The ADON said the first page should be filled out by us and the second page by the dialysis center and if it was not done a call should be made and a progress note written, but this does not always happen. She said there were many days of communication missing and the communication should be better. During a follow up interview on 7/25/24 at 3:40 P.M., UM #1 said she documents the post-weights in the computer from the post-it/sticky note if they send one or she will call to get the weight, but the daily communication is not good. She said the dialysis center will call if there is a significant problem and do not communicate how Resident #102 tolerated the procedure routinely or answer any of the questions on the communication form.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48084 Based on observations, records reviewed, policy review, and interviews, the facility failed to ensure it was free of a medication error rate of five percent or greater when one of five nurses made four errors in 27 opportunities, totaling a medication error rate of 14.81%. These errors impacted one Resident (#211), out of seven residents observed. Findings include: Review of the facility's policy titled Administering Medications, dated as last revised April 2019, indicated but was not limited to the following: -Medications are administered in a safe and timely manner, and as prescribed. -Medications are administered in accordance with prescriber orders. -The individual administering the medication check the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. -Each nurses' station has a current Physician Desk Reference (PDR) and/or access to another medication reference. Review of the facility's policy titled Preparation and General Guidelines, dated November 2021, indicated but was not limited to the following: -An individualized approach should be used when altering dosage forms by crushing or opening capsules. -An order to crush medications may be required or preferred in accordance with State regulation of facility preference. -Orders to crush medications should not be applied to medications which, if crushed, present a risk to the resident. For example: long acting or Enteric Coated forms should not be crushed; an alternative should be sought. -The instructions or crushing medications should be included on the resident's orders and the medication administration record (MAR/eMAR) so all personnel administering medications are aware of this need. On 7/24/24 at 9:20 A.M., the surveyor observed Nurse #1 prepare nine morning medications for Resident #211, eight of which were to be administered by mouth and one was a topical patch: a. Ferrous Sulfate 325 milligrams (mg) (iron supplement) b. Acidophilus with Pectin capsule (probiotic with soluble fiber additive) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225437	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarwood Rehabilitation & Healthcare Center	150 Lincoln Street Needham, MA 02492

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Loratadine 10 mg (allergies) d. Acetaminophen 500 mg (2 tablets) (pain relief) e. Alfuzosin HCL ER (extended release) 10 mg (long acting for enlarged prostate) f. Eliquis 2.5 mg (2 tablets) (anticoagulant) g. Metoprolol Succinate ER 25 mg (long acting for blood pressure) h. Rosuvastatin 10 mg (treat high cholesterol) i. Lidoderm 4% Pain Patch (pain) -Seven pills/tablets were put into a medication cup and one capsule was put into a separate cup. -The seven pills/tablets were all crushed together, and the powder mixed with applesauce. -The one capsule was opened, and the contents mixed with the applesauce. Review of the [NAME] Drug Book, 19th edition, indicated the following: -Acidophilus did not contain Pectin. -Ferrous Sulfate tablet should be taken with a full glass of water or juice and tablets should not be crushed or chewed. -Alfuzosin was an extended-release tablet and should not be crushed. -Metoprolol Succinate was an extended-release tablet and should not be crushed. Review of the Physician's Orders to reconcile the medications ordered versus the medications administered indicated the following four errors: -Acidophilus Capsule 10 mg once daily was ordered but Acidophilus with Pectin was administered. -Ferrous Sulfate 325 mg tablet was ordered but was administered crushed. -Alfuzosin HCL ER 10 mg was ordered but was administered crushed. -Metoprolol Succinate ER 25 mg was ordered but was administered crushed. Review of the medication cards used by the nurse to prepare the Alfuzosin HCL ER and Metoprolol Succinate ER indicated that a green sticker from the pharmacy was on the card and it read SWALLOW WHOLE DO NOT CRUSH OR CHEW. During an interview on 7/24/24 at 9:25 A.M., Nurse #1 said she crushed all the medications except the Acidophilus, she said she opened that capsule and mixed all the medications with applesauce. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/24/24 at 1:35 P.M., Nurse #1 said the Acidophilus with Pectin was the only one they had in the facility, and she thought it was the same as regular Acidophilus. She said she thought Ferrous Sulfate could be crushed and it was only the Slow FE (ferrous sulfate) that could not be crushed. Additionally, she said the Alfuzosin and Metoprolol Succinate are both extended release and say not to crush them, so she should not have crushed those medications, but Resident #211 had been having trouble swallowing so she had to crush the medications. During an interview on 7/25/24 at 10:20 A.M., Unit Manager (UM) #1 said she thought Ferrous Sulfate could be crushed. Additionally, she said the Acidophilus with Pectin is the only one they have in the facility, and it is basically the same thing. She said the Pectin just helps hold the capsule together. UM #1 said the Alfuzosin and Metoprolol Succinate should not have been crushed. During an interview on 7/25/24 at 3:00 P.M., the Assistant Director of Nurse (ADON) said the Ferrous Sulfate, Alfuzosin, and Metoprolol Succinate should not be crushed. She said those medications should be administered whole in applesauce or pudding or they would need to obtain an order for a different medication. She said Acidophilus with Pectin is not the same as Acidophilus and they would have to change the order or order the correct house stock.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15214 Based on record review and interview, the facility failed to ensure that the COVID-19 testing policy was followed during a COVID-19 outbreak. Specifically, the facility failed to conduct 48-hour testing intervals for residents and staff in accordance with its COVID-19 testing requirements policy. Findings include: Review of the facility's Infection Control program policy for COVID-19 Testing Requirements-MA, last revised 5/11/23, indicated but was not limited to the following: Outbreak Testing: -If a new case of COVID-19 is identified, the facility will test exposed residents and staff at least every 48 hours on the affected unit until the facility goes 7 days without a new case unless a DPH epidemiologist directs otherwise. During an interview on 7/26/24 at 9:33 A.M., the Infection Preventionist (IP) said that the facility experienced a COVID-19 outbreak on the [NAME] Unit on 6/26/24, where two residents tested positive. She said that 6/26/24 was Day 0. The IP said that she had not received additional guidance or recommendations from a DPH epidemiologist in regard to testing for COVID, so the facility followed their policy for outbreak testing. Review of the IP's testing schedule of residents on the [NAME] Unit during the COVID-19 outbreak indicated testing was not conducted every 48 hours on the affected unit until the facility goes 7 days without a new case as follows: 6/24/24- Two residents test COVID-19 positive; all residents tested 6/26/24- One resident tested who was showing signs/symptoms of COVID-19. The remaining residents were not tested . 6/27/24- All residents tested on the [NAME] Unit, 4 residents tested positive for COVID-19 6/29/24- All residents tested on the [NAME] Unit, a total of 13 residents tested positive for COVID-19 7/1/24- All residents tested on the [NAME] Unit, 13 residents tested positive for COVID-19 7/3/24- Log does not reflect that residents were tested 7/5/24- All residents tested on the [NAME] Unit, 7 residents tested positive for COVID-19 7/7/24- No evidence that residents were tested 7/8/24- All residents tested on the [NAME] Unit, 4 Residents tested positive for COVID-19 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/10/24- All residents tested on the [NAME], all tested negative for COVID-19 During an interview on 7/26/24 at 12:42 P.M., the [NAME] Unit Nurse Manager said that all of the [NAME] Unit residents were tested for COVID-19 on 7/3/24, however 10 residents remained positive. Review of Staff testing logs for COVID-19 indicated testing began on 6/24/24. The facility testing schedule indicated that staff testing was conducted as follows: 6/24/24- All staff on the [NAME] Unit were tested for COVID-19, no positives were detected. 6/26/24- No testing conducted as required. 6/27/24- All staff on the [NAME] Unit were tested for COVID-19, no positives were detected 6/29/24- All staff on the [NAME] Unit were tested for COVID-19, no positives were detected 7/1/24- All staff on the [NAME] Unit were tested for COVID-19, no positives were detected During an interview on 7/26/24 at 12:48 P.M., the IP said that she could not provide documentation to demonstrate that COVID-19 testing had been conducted on 7/7/24 on the [NAME] unit in accordance with the facility policy or that all staff who worked on the [NAME] Unit had been tested for COVID-19 on 6/26/24, 48 hours after the initial outbreak testing began. During an interview on 7/26/24 at 1:19 P.M., the Assistant Director of Nursing (ADON) said that the COVID-19 testing procedure was not conducted in accordance with the facility's COVID-19 testing requirements policy.