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	06/17/2026

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

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, the facility failed to document whether the facility educated its staff about severe acute respiratory syndrome (SARS) or the COVID-19 vaccine, or whether its staff received the COVID-19 vaccine. Findings include:Review of the facility policies for COVID-19 Vaccine and Employee Infection and Vaccination Status, last reviewed in 2026, indicated:Prior to or upon an employee's duty assignment, the facility will assess the status of an employee's vaccination against infectious conditions, screening and recent history of communicable diseases. Employees will be current with mandated vaccinations prior to performing resident care. Documentation of vaccinations include the signature of a licensed healthcare provider and employee when being administered. Vaccinations that are declined by the employee are documented on the applicable (sic). During an interview with the Infection Preventionist on 6/17/26 at 7:47 A.M., the surveyor requested documentation that one sampled employee had been provided education about severe acute respiratory syndrome (SARS) or the COVID-19 vaccine, and whether the employee either accepted or declined the vaccine. The Infection Preventionist said she did not think the facility documented employees' education or vaccination status. The surveyor then asked the Infection Preventionist to provide documented education and vaccination status for an additional four sampled staff members. The Infection Preventionist said the facility did not keep employee records of SARS or COVID-19 vaccine education, or a record of any of their employees' SARS and COVID-19 education or whether they had received the COVID-19 vaccine. During an interview with Nurse Consultant #1 on 6/17/26 at 11:01 A.M., she said the facility had not documented whether the five sampled staff had declined or been administered the COVID-19 vaccine.

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure for one resident (#129) out of a total sample of 25 residents, that standards in quality nursing care were provided in accordance with the physician's orders. Specifically, for Resident #129:A. facility staff failed to implement the order to check the external length of the IV (intravenous) catheter with the dressing change and as needed. and B. facility staff failed to obtain an order and document an intravenous dressing change dated 6/14/26, which was outside of the established physician's orders to change the intravenous catheter every seven days.Findings include:Review of the [NAME] & [NAME] article, when to use a midline catheter, dated April 2025 indicated: Monitor catheter migration by measuring and documenting the external catheter length at each dressing change. Use a site stabilizing device to help prevent catheter migration.Review of the facility's policy, titled ?Peripheral and Midline IV (intravenous) Dressing Changes, revision date October 2024, indicated the following:This (sic) purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter- related infections associated with contaminated, loosened or soiled catheter- site dressings. General guidelines include but are not limited to the following: 1. Perform site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised (e.g., damp, loosened, or visibly soiled). Documentation: The following should be documented in the resident's medical record: a. date, time type of dressing, and reason for dressing change. b. Any complications/interventions related to insertion side or surrounding area, and c. Resident's response to procedureResident #129 was readmitted to the facility in June 2026 with diagnoses that included osteomyelitis in vertebra, pressure ulcer of the sacral ulcer, sepsis, chronic kidney disease, and adult failure to thrive.Review of Resident #129's Minimum Data Set (MDS) assessment, dated 5/28/26, indicated he/she was assessed by nursing staff to have severe cognitive impairment.During an observation on 6/15/26 at 10:30 A.M., Resident #129 was in bed, with his/her eyes closed and could not be interviewed. An IV pole was located next to his/her bed.Review of Resident #129's hospital discharge summary indicated Resident #129 had a Midline Double Lumen (a midline is peripheral intravenous catheter inserted into a vein in the upper arm, used for intermediate duration IV therapy), placement on 6/2/26. A. Review of Resident #129's physician order, dated 6/3/26, indicated IV: (Midlines and PICCs (peripherally inserted central catheter) Document baseline external length of IV catheter, check external length with each dressing change and as needed.Review of the Medication Administration Record dated June 2026 indicated the order to check the external length of the IV catheter was documented as blank and not signed by nursing staff on 6/4/26 and documented NA and initialed by Nurse #1 on 6/11/26. Review of the chart codes indicated NA = No interventions required.Review of Resident #129's care plans failed to indicate a person-centered care plan with a measurable goal and specific interventions was developed for the administration of intravenous therapy.Review of Resident #129's clinical record including the Medication Administration Record (MAR), Treatment Administration Record (TAR) and, progress notes dated 6/3/26 through 6/16/26 failed to indicate documentation that the external length of the IV catheter was obtained on 6/4/26 and 6/11/26 in accordance with the physician's order.During an interview on 6/17/26 at 9:08 A.M., Nurse #1 said Resident #129 has an IV for antibiotics to treat a wound infection. Nurse #1 said nursing staff follow the physician's order for the intravenous care and that the IV dressing is changed weekly on the evening shift. Nurse #1 said she did not measure the external length of the IV catheter on 6/11/26 and that is why she documented NA.During an interview on 6/17/26 at 9:43 A.M., Unit Manager #1 said it is not the facility policy to measure a midline IV catheter. Unit Manager #1 said unless the order is changed the nursing staff should follow the physician's order. During an interview on 6/17/26 at 10:38 A.M., the Director of Nursing said the nursing staff should review the orders and unless they ask the nurse practitioner or physician for (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clarification of an order the physician's order should be completed as ordered.B. During an observation and interview on 6/17/26 at 9:08 A.M., Nurse #1 and the surveyor observed Resident #129's dressing to the IV site on his/her right upper arm. Nurse #1 said the dressing date handwritten on the dressing read 6/14/26. Nurse #1 said the dressing is changed every seven days on the evening shift.Review of the MAR indicated an order: IV (midline, PICC (peripheral inserted central catheter), CVAD (central venous access device)) change transparent dressing on admission and then every 7 days, caps to be changed during dressing changes one time only until 6/4/26 one time, was documented by nursing staff as administered on 6/5/26 (one day after the one time only date of 6/4/26). Further review of the MAR indicated the order: IV (Midline and PICC, CVAD) change transparent dressing on admission and then every 7 days; caps to be changed during dressing changes. One time a day every 7 days. Start date 6/4/26 and was documented by nursing staff as administered on 6/11/26. Review of Resident #129's clinical record including the MAR, Treatment Administration Record (TAR) and, progress notes dated 6/3/26 through 6/16/26 failed to indicate that there was documentation that a physician's order to change the IV dressing on 6/14/26 was ordered. In addition, neither the MAR nor progress notes indicated the reason the IV dressing was changed, or documentation of Resident #129's response to the procedure of the dressing change.During an interview on 6/17/26 at 10:38 A.M., the Director of Nursing said there was no order for the dressing change dated 6/14/26 and that there should have been. The DON said there was no documentation in Resident #129's progress notes as to why the dressing was changed outside of the physician's order and that there should have been documentation entered by the nurse.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, records reviews and interviews, the facility failed for two Residents (#6 and #12), to maintain medical records accurately and reflect the resident's status. Specifically,1. Nursing staff failed to maintain an accurate medical record, when they documented Resident #6 had a central venous catheter when he/she had it removed, and2. Nursing staff failed to maintain an accurate medical record, when they documented Resident #12 had a blood sugar monitoring device that he/she did not have.Findings include: 1. Resident #6 was admitted to the facility in [DATE] and has diagnoses that include end stage renal disease, and dependence on renal dialysis. Review of the most recent Minimum Data Set assessment, dated [DATE], indicated Resident #6 scored 14 out of 15 on the Brief Interview for Mental Status exam, indicating he/she as cognitively intact. Further, the MDS indicated Resident #6 is on dialysis. During an observation and interview on [DATE] at 8:32 A.M., Resident #6 said he/she goes out for dialysis on Tuesdays, Thursdays, and Saturdays. Resident #6 said the access site for dialysis is his/her right arm. Resident #6 moved his/her right arm out revealing a large linear bulge on his/her arm. During an observation and interview on [DATE] at 4:14 P.M. Resident #6 said he/she did have a port in his/her left chest and that it was removed about one month ago. Resident moved his/her johnny revealing a small red area, there was no central port catheter present. Review of Resident #6's clinical record indicated an 'After Visit Summary: dated [DATE] indicated left TDC (tunneled dialysis catheter) removal completed. Review of Resident #6's Treatment Administration Record (TAR) dated [DATE] indicated the following order: Access site: Left chest wall, access type: central catheter Monitor dialysis access site for sign/symptoms of infection, drainage, bruising, and bleeding every shift, and as clinically indicated. Every shift Document abnormal findings in the progress notes and report to the physician. Start date [DATE]. Further, the [DATE], TAR indicated nursing staff signed off day, evening and night shifts on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. This documentation entered by nursing staff was completed after the left chest wall access central line catheter was removed, thus rendering the documentation as inaccurate and not reflecting Resident #6 clinical status. During an interview on [DATE] at 3:54 P.M., Nurse #2 said Resident #6 returns from dialysis on the day shift around 2:00 P.M., When asked where Resident #6's access site for dialysis is, Nurse #2 said she believes the Resident has a port in his/her chest. Nurse #2 said she goes by the physician's orders to assess Resident #6 and does a head-to-toe visual check of the Resident at the start of her shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 4:30 P.M., Unit Manager #1 said Resident #6 has an arm fistula which is not in use yet. Unit Manager #1 said her understanding is that Resident #6 has a left chest wall port for dialysis access. During an interview on [DATE] at 1:28 P.M. Unit Manager #1 said she did not know that Resident #6 was now receiving his/her dialysis treatment through his/her right arm fistula. Unit Manager #1 said Resident #6's left chest wall catheter was removed and that nursing staff should not sign off the order that is not provided. During an interview [DATE] at 1:31 P.M., Nurse #1 reviewed the TAR and said she signed the order for the left chest wall catheter and said she was confused about the order. During an interview on [DATE] at 8:22 A.M., the Director of Nurses (DON) said she expects nurses to sign off orders only if they are completed. The DON said the Resident no longer had the chest wall catheter, and the nursing staff should have been aware and should have reviewed the order, got clarification and not signed off on the order. 2. Resident #12 was admitted to the facility in [DATE] with diagnoses that included Type 2 Diabetes, chronic kidney disease, dementia and adult failure to thrive. Review of the most recent Minimum Data Set (MDS) assessment, dated [DATE], indicated he/she scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. During an interview on [DATE] at 8:48 A.M., Resident #12 said the sensor was not working over the weekend, and the staff is waiting for a new one from the pharmacy. Review of Resident #12's physician order, dated [DATE], indicated Dexcom G7 15 Day Sensor Miscellaneous (Continuous Glucose System Sensor). Inject 1 application subcutaneously one time a day every 15 day(s). Review of Resident #12's physician order, dated [DATE], indicated FreeStyle Libre 2 Plus Sensor Miscellaneous (Continuous Glucose System Sensor). Inject 1 application subcutaneously one time a day every 14 day(s). Review of Resident #12's physician order, dated [DATE], indicated Dexcom G7 15 Day Sensor. Collect and keep it charge at nurse med room, keep it on charge during the shift at bedtime for Dexcom. Review of Resident #12's [DATE] Medication Administration Record (MAR) indicated nursing staff applied the Libre 2 Plus sensor on [DATE]. Review of Resident #12's [DATE] Medication Administration Record (MAR) indicated nursing staff applied the Dexcom sensor on [DATE]. Review of Resident #12's [DATE] Medication Administration Record (MAR) indicated nursing staff from [DATE] through [DATE] and on [DATE] signed off the Dexcom G7 day sensor order as administered. During an interview and observation on [DATE] at 12:45 P.M., Resident #12 said he/she has been (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	using a Libre 2 Plus sensor and not a Dexcom sensor. Resident #12 then showed the surveyor his/her upper arm confirming it was a Libre 2 plus sensor. During an interview on [DATE] at 1:38 P.M., Nurse #1 said the nurse on evening shift yesterday ([DATE]) applied the new Libre 2 Plus sensor when it arrived last night. Nurse #1 said she removed the old Libre 2 Plus sensor on Saturday during the day shift as it was no longer working. Nurse #1 said there was not another sensor to put on Saturday. During an interview on [DATE] at 1:39 P.M., Unit Manager #1 said they have had trouble getting the Libre 2 Plus so the Resident did not get a replacement Libre [NAME] until the evening shift on [DATE]. Unit Manager #1 said to her knowledge the Resident has never had a Dexcom sensor here at the facility. The Unit Manager said nurses should not be signing off orders as administered unless they actually are administered. During an interview on [DATE] 3:52 P.M., Nurse #2 said she did apply the new Libre 2 Plus sensor when it arrived around 10:00 P.M. on [DATE]. Nurse #2 said the old sensor expired and staff had to wait for a new one to arrive. Nurse #2 said she never knew of a Dexcom sensor for this Resident. During an interview on [DATE] at 8:22 A.M., the Director of Nurses (DON) said she expects nurses to sign off orders only if they are actually completed. The DON said nurses should not have been signing off two different sensors when the Resident has only had a Libre 2 Plus sensor applied.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and interview, the facility failed to ensure it offered one Resident (#97) of 5 sampled residents the pneumococcal and COVID-19 vaccines.Findings include:Review of the facility policy for administration of the pneumococcal vaccine to residents, last reviewed in 2026, indicated: All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. - Prior to or upon admission, resident will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series unless medically contraindicated or the resident has already been vaccinated.- Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education shall be documented in the resident's medical record. - Resident/representative have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination. Review of the facility policy for the administration of the COVID-19 vaccine to residents, last reviewed in 2026, indicated: All residents will be offered the COVID-19 vaccine to aid in preventing severe acute respiratory syndrome (SARS) virus. - Before receiving a COVID-19 vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the vaccine. Provision of such education shall be documented in the resident's medical record. - Resident/representative has the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the COVID-19 vaccination. Resident # 97 was admitted to the facility in April 2026. Review of Resident #97's medical record on 6/15/26 indicated there was no reference to staff offering either the pneumococcal or COVID-19 vaccines, or of the Resident accepting or refusing to accept the vaccines.During an interview with Resident #97 on 6/17/26 at 8:05 A.M., he/she said staff had not offered any vaccines to him/her on admission, which occurred approximately ten weeks ago. Resident #97 said the first time staff offered any vaccines to him/her was yesterday, on 6/16/26. Resident #97 said he/she signed consents to have the pneumococcal and RSV (respiratory syncytial virus) vaccines but declined the COVID-19 vaccine. During interviews with the Infection Preventionist and Nurse Consultant #1 on 6/17/26 at 11:00 A.M., they said they thought staff had offered the pneumococcal and COVID-19 vaccines to Resident #97 on admission to the facility, but there was no record of this, or of the Resident refusing vaccines. Review of Resident #97's medical record on 6/17/26 indicated he/she signed informed consent forms to receive the RSV and pneumococcal vaccines and to decline the COVID-19 vaccine.