

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495240	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Fredericksburg Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 Plank Road Fredericksburg, VA 22407	

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)
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to implement the baseline care plan for one of six residents in the survey sample, Resident #3. The findings include: For Resident #3 (R3), the facility staff failed to implement the resident's baseline care plan for oxygen administration. A review of R3's clinical record revealed a physician's order dated 1/30/26 for oxygen at two liters per minute for chronic obstructive pulmonary disease (lung disease). R3's baseline care plan dated 2/2/26 documented, I have alteration in Respiratory Status wheezing, SOB (Shortness of Breath), Obstructive Sleep Apnea. Administer oxygen as needed per Physician order. On 2/4/26 at 11:30 a.m., R3 was observed lying in bed receiving oxygen at a rate between three liters and four liters (as evidenced by the ball in the oxygen concentrator flow meter between the three-liter line and the four-liter line). On 2/4/26 at 2:14 p.m., R3 was observed lying in bed receiving oxygen at a rate between two and three liters (as evidenced by the ball in the oxygen concentrator flow meter between the two-liter line and the three-liter line). During both observations, the oxygen concentrator was not within the resident's reach. On 2/4/26 at 3:02 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 stated the purpose of the care plan is that it provides information so staff can meet residents' needs. LPN #1 stated nurses have access to look at residents' care plans to ensure they are implementing them. LPN #1 stated nurses should check the physician's order to ensure the correct amount of oxygen is administered to a resident. LPN #1 stated if a resident is supposed to receive two liters of oxygen, nurses should verify this by looking at the oxygen concentrator flow meter at eye level and making sure the middle of the ball runs through the two-liter line in the flow meter. On 2/4/26 at 4:02 p.m., ASM (Administrative Staff Member) #1 (the Administrator) and ASM #2 (the Director of Nursing) were made aware of the above concern. The facility policy titled, Care Plan documented, 2. A Baseline Care plan must be developed within 48 hours of admission to insure that the resident's needs are met appropriately until the Comprehensive Care Plan is completed. No further information was presented prior to exit.</p>

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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide respiratory care and services for two of six residents in the survey sample, Residents #2, and #3. The findings include: 1. For Resident #2 (R2), the facility staff failed to post cautionary and safety signage, indicating the use of oxygen. A review of R2's clinical record revealed a physician's order dated 1/17/26 for oxygen at two liters per minute for shortness of breath. On 2/4/26 at 9:28 a.m., and 11:23 a.m., R2 was observed lying in bed, receiving oxygen at two liters per minute via a nasal cannula and oxygen concentrator. No cautionary and safety signs, indicating the use of oxygen, were observed at the resident's doorway or in the room. On 2/4/26 at 3:02 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 stated that when a resident is receiving oxygen, there is supposed to be a sign outside of the room door that documents oxygen is in use. LPN #1 stated the purpose of the sign is to alert staff that the resident requires oxygen, and for safety because oxygen is flammable. On 2/4/26 at 4:02 p.m., ASM (Administrative Staff Member) #1 (the Administrator) and ASM #2 (the Director of Nursing) were made aware of the above concern. The facility policy titled, Oxygen Administration documented, Safety and Storage: 1. Oxygen is considered a fire hazard and must be handled with caution .3. Post 'Oxygen in Use' signage where applicable. No further information was presented prior to exit. 2. For Resident #3 (R3), the facility staff failed to administer oxygen at the physician prescribed rate of two liters per minute. A review of R3's clinical record revealed a physician's order dated 1/30/26 for oxygen at two liters per minute for chronic obstructive pulmonary disease (lung disease). On 2/4/26 at 11:30 a.m., R3 was observed lying in bed receiving oxygen at a rate between three liters and four liters (as evidenced by the ball in the oxygen concentrator flow meter between the three-liter line and the four-liter line). On 2/4/26 at 2:14 p.m., R3 was observed lying in bed receiving oxygen at a rate between two and three liters (as evidenced by the ball in the oxygen concentrator flow meter between the two-liter line and the three-liter line). During both observations, the oxygen concentrator was not within the resident's reach. On 2/4/26 at 3:02 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 stated nurses should check the physician's order to ensure the correct amount of oxygen is administered to a resident. LPN #1 stated if a resident is supposed to receive two liters of oxygen, nurses should verify this by looking at the oxygen concentrator flow meter at eye level and making sure the middle of the ball runs through the two-liter line in the flow meter. On 2/4/26 at 4:02 p.m., ASM (Administrative Staff Member) #1 (the Administrator) and ASM #2 (the Director of Nursing) were made aware of the above concern. The oxygen concentrator manufacturer's instructions documented, 5. Adjust the flow to the prescribed setting by turning the knob on the top of the flow meter until the ball is centered on the line marking the specific flow rate. The facility policy titled, Oxygen Administration documented, Administration Procedure: 2. Verify the physician's order prior to initiation .5. Apply the correct delivery device and prescribed flow rate. No further information was presented prior to exit.</p>		