| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495431 | A. Building<br>B. Wing | 12/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Berea Health & Rehab Center | 55 Brimley Drive<br>Fredericksburg, VA 22406 |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>(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 |
|---|---|---|
| | | |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on staff interview, facility document review, and clinical record review, the facility staff failed to preserve a resident's right for the notification of the provider and RR (resident representative) of a change in condition for two of five residents in the survey sample, Residents #1 and #2.The findings include:1. For Resident #1 (R1), the facility staff failed to notify the provider and RR of blood sugar levels exceeding 400 on multiple occasions in September and November 2025.A review of R1's provider's orders revealed the following order dated 9/16/25: Insulin lisproSolution (1); 100 unit/mL (milliliter); Amount to Administer: Per Sliding Scale.If blood sugar is greater than 400, call MD (medical doctor).A review of R1's MARs (medication administration records) revealed the following dates and times when R1's blood sugar was greater than 400: 9/14/25 1:01 p.m. Blood Sugar: 452; 9/17/2025 5:27 p.m. Blood Sugar: 435; 9/18/25 12:58 p.m. Blood Sugar: 449; 11/20/25 5:22 p.m. Blood Sugar: 461. Further review of R1's clinical record revealed no evidence that either the provider or the RR was notified of these blood sugar levels.On 12/3/25 at 3:37 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated that orders for sliding scale insulin administration most always include the instruction to contact the provider if the blood sugar is above a dangerously high level. She stated if she obtained a blood sugar reading that exceeded the parameter, she would notify both the provider and the RR (resident representative). She added: An order is an order.On 12/3/25 at 4:06 p.m., ASM (administrative staff member) #1, the regional director of clinical services, ASM #2, the director of nursing, and ASM #3, the regional vice president of operations, were informed of these concerns. On 12/3/25 at 4:16 p.m., RN (registered nurse) #1, a unit manager, was interviewed. He stated that the local hospital frequently discharges residents to the facility with orders for frequent blood sugar checks and for insulin administration according to the blood sugar readings. He stated that while the facility is in the process of reviewing the orders containing instructions to call the provider with blood sugar levels over a certain amount, the nurses are responsible for following the orders as currently stated. He explained that he had reviewed R1's blood sugars and could not find evidence that either the provider or RR had been notified when the blood sugar level exceeded 400. A review of the facility policy, Resident Change in Condition, revealed, in part: The licensed nurse will recognize and intervene in the event of a change in resident condition. The Physician/Provider and the Family/Responsible Party will be notified as soon as the nurse has identified the change in condition and the resident is stable.No additional information was provided prior to exit.Reference(1) Insulin lispro injection products are used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). Insulin lispro injection products are also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information is taken from the website https://medlineplus.gov/druginfo/meds/a697021.html?utm_source=mplusconnect&utm_medium=application.2. For Resident #2 (R2), the facility staff failed to notify the provider and RR of blood sugar levels exceeding 400 on multiple occasions in September and October 2025.A review of R2's provider's orders revealed the following order dated 8/25/25: Novolog FlexPen U-100 Insulin (insulin aspart u-100) insulin pen (1); 100 unit/mL (milliliter); Amount to Administer: Per Sliding Scale.If blood sugar is greater than 400, call NP/PA (nurse practitioner/physician assistant).A review of R2's MARs (medication administration records) revealed the following dates and times when R2's blood sugar was greater than 400: 9/2/25 at 5:00 p.m. Blood Sugar 423; 9/18/25 at 8:00 a.m. Blood Sugar 435; 9/19/25 at 8:00 a.m. Blood Sugar 413; 9/19/25 at 5:00 p.m. Blood Sugar 503; 9/26/25 at 5:00 p.m. Blood Sugar 432; 10/9/25 at 12:00 p.m. Blood Sugar HIGH; 10/27/25 at 5:00 p.m. Blood Sugar HIGH. Further review of R2's clinical record revealed no evidence that the either the provider or RR was notified of these blood sugar levels.On 12/3/25 at 3:37 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated that orders for sliding scale insulin administration most always include the instruction to contact the provider if the blood sugar is above a dangerously high level. She stated if she obtained a blood sugar reading that exceeded the parameter, she would notify both the provider and the RR (resident representative). She added: An order is an order.On 12/3/25 at 4:06 p.m., ASM (administrative staff member) #1, the regional director of clinical services, ASM #2, the director of nursing, and ASM #3, the regional vice president of operations, were informed of these concerns. On 12/3/25 at 4:16 p.m., RN (registered nurse) #1, a unit manager, was interviewed. He stated that the local hospital frequently discharges residents to the facility with orders for frequent blood sugar checks and for insulin administration |

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|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow the provider's order for the administration of insulin for two of five residents in the survey sample, Residents #1 and #2.The findings include:1. For Resident #1 (R1), the facility staff failed to follow the provider's order to notify the provider of blood sugar levels exceeding 400 on multiple occasions in September and November 2025.A review of R1's provider's orders revealed the following order dated 9/16/25: Insulin lisproSolution (1); 100 unit/mL (milliliter); Amount to Administer: Per Sliding Scale.If blood sugar is greater than 400, call MD (medical doctor).A review of R1's MARs (medication administration records) revealed the following dates and times when R1's blood sugar was greater than 400: 9/14/25 1:01 p.m. Blood Sugar: 452; 9/17/2025 5:27 p. m. 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He stated that the local hospital frequently discharges residents to the facility with orders for frequent blood sugar checks and for insulin administration according to the blood sugar readings. He stated that while the facility is in the process of reviewing the orders containing instructions to call the provider with blood sugar levels over a certain amount, the nurses are responsible for following the orders as currently stated. He explained that he had reviewed R1's blood sugars and could not find evidence that the provider had been notified when the blood sugar level exceeded 400. He stated the nurses had not followed the provider's order in those cases in which the provider had not been notified.A review of the facility policy, Physician/Provider Orders, revealed no information related to the nursing staff's responsibility to follow providers' orders.No additional information was provided prior to exit.Reference(1) Insulin lispro injection products are used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). Insulin lispro injection products are also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information is taken from the website https://medlineplus.gov/druginfo/meds/a697021. html?utm_source=mplusconnect&utm_medium=application.2. 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