STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495431	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berea Health & Rehab Center	55 Brimley Drive 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interview, and facility document review, it was determined that the facility staff failed to store food, in one of one kitchens, in a sanitary manner.The findings include:On 3/3/26 at 12:00 PM, an observation was conducted in the kitchen with the following findings: in the walk-in refrigerator, observation of a two-gallon zip lock bag unsealed with fish dated 3/2/26. The cook sealed the zip lock bag. The cook stated, the bag should be completely sealed, it was not, our standard is to have refrigerated food in sealed containers.On 3/4/26 at 5:00 PM, the Administrator and the Director of Nursing were informed of the above concerns.A review of the facility's Storage of Refrigerated Foods policy revealed, Store all food/leftovers in covered, approved, food grade containers.No further information was provided prior to exit.

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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(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 - Some	Provide and implement an infection prevention and control program. Based on observation, staff interview and facility document review, it was determined that the facility staff failed to follow infection control practices for two of 36 residents in the survey sample, Residents #26 and #17 and in one of one laundry room.The findings include:1. For Resident #26 (R26), the facility staff failed to disinfect a blood pressure cuff prior to use on 3/4/2026. On 3/4/2026 at 8:15 AM, an observation was made of registered nurse (RN) #1 rolling a vital sign monitor over to Resident #75 in the dining area on the unit where they resided at the facility and checking their blood pressure. RN #1 did not disinfect the blood pressure cuff after use. At 8:23 AM, RN #1 was observed using the same blood pressure cuff and monitor to check the blood pressure of Resident #26 in their room without disinfecting it prior to use or after use. On 3/4/2026 at 2:17 PM, an interview was conducted with RN #1 who stated that the blood pressure cuffs should be cleaned using the disinfectant wipes after each use. She stated that she was nervous and had forgotten to disinfect the blood pressure cuff during the observation that morning. On 3/5/2026 at 8:06 AM, an interview was conducted with licensed practical nurse #3 who stated that the nurses normally did their own vital signs and they had a system to disinfect the monitor and cuff between each use. The facility provided policy, Cleaning and Disinfection of Resident Care Equipment revised 7/7/2025, documented in part, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to CDC (Centers for Disease Control) and EPA (Environmental Protection Agency) recommendations for disinfection . According to the CDC's Disinfection of Healthcare Equipment it documented in part, . Medical equipment surfaces (e.g., blood pressure cuffs, stethoscopes, hemodialysis machines, and X-ray machines) can become contaminated with infectious agents and contribute to the spread of health-care–associated infections. For this reason, noncritical medical equipment surfaces should be disinfected with an EPA-registered low- or intermediate-level disinfectant. Use of a disinfectant will provide antimicrobial activity that is likely to be achieved with minimal additional cost or work . This information was obtained from the website: Disinfection of Healthcare Equipment | Infection Control | CDC On 3/4/2026 at approximately 5:25 PM, Administrator #1, Administrator #2, the Director of Nursing, the Infection Preventionist and the Administrator in Training were made aware of the findings. No further information was presented prior to exit. 2. For Resident #17 (R17), the facility staff failed to disinfect a blood pressure cuff prior to use on 3/4/2026. On 3/4/2026 at 8:23 AM, an observation was made of registered nurse (RN) #1 rolling a vital sign monitor into Resident #26's room and using a blood pressure cuff to check their blood pressure without disinfecting it after use. At 8:37 AM, RN #1 was observed checking Resident #17's blood pressure in their room with the same blood pressure monitor and blood pressure cuff without disinfecting it prior to use or after use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/4/2026 at 2:17 PM, an interview was conducted with RN #1 who stated that the blood pressure cuffs should be cleaned using the disinfectant wipes after each use. She stated that she was nervous and had forgotten to disinfect the blood pressure cuff during the observation that morning. On 3/5/2026 at 8:06 AM, an interview was conducted with licensed practical nurse #3 who stated that the nurses normally did their own vital signs and they had a system to disinfect the monitor and cuff between each use. On 3/4/2026 at approximately 5:25 PM, Administrator #1, Administrator #2, the Director of Nursing, the Infection Preventionist and the Administrator in Training were made aware of the findings. No further information was presented prior to exit. 3. The facility staff failed to use a separate entrance into the facility's laundry room for soiled linens to prevent cross contamination. On 03/05/2026 at approximately 10:00 a.m. an observation in the facility's utility hallway revealed a sign on a door on the right side of hallway that documented, Soiled Laundry. Observation of the next doorway on the right led to the clean side of the laundry room. Upon entering observations revealed tables for folding clean laundry to the left and clothes dryers straight ahead. Continued observations revealed clothes washing machines and soiled laundry bin to the right. At approximately 10:05 a.m., an observation revealed a housekeeper/laundry aide pushed a bin, containing three compartments of soiled laundry, through the entrance and down the short hallway entering the clean side of the laundry room to the clothes washers. Further observation revealed that the housekeeper/laundry aide did not enter the laundry room with soiled laundry through the soiled laundry room door. On 03/05/2026 at approximately 10:00 a.m. an interview was conducted with the facility's Director of Housekeeping and Laundry. When informed of the observation stated above, he stated that clean and soiled laundry should not be taken I and out through the same door to prevent cross contamination. The facility's policy Linen Management Policy documented in part, Policy: Linens will be handled, transported and processed in a manner which reduces the risk of contamination or cross-contamination. On 03/05/2026 at approximately 3:04 p.m., the Administrator # 2 and the Director of Nursing, were made aware of the findings. No further information was presented prior to exit.

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	495431	A. Building B. Wing	03/05/2026

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to promote dignity for one of 36 residents in the survey sample, Resident #75.The findings include:For Resident #75 (R75), the facility staff failed to promote dignity when they checked the residents blood pressure in the dining room during breakfast on 3/4/2026.On the most recent minimum data set (MDS), a quarterly assessment with an assessment reference date (ARD) of 11/25/2025, the resident scored four out of 15 on the brief interview for mental status (BIMS) assessment, indicating they were severely impaired for making daily decisions.On 3/04/2026 at 8:15 AM, an observation was made of R75 sitting in the dining area on the unit where they resided at a table with two other residents eating breakfast. R75 was observed to have finished their breakfast and was sitting at the table with the other residents who were still eating. Registered nurse #1 was observed rolling a vital sign monitor over to R75 at the table and proceeded to check their blood pressure at the table in the dining room.On 3/5/2026 at 8:06 AM, an interview was conducted with licensed practical nurse #3 who stated that residents vital signs were taken in the residents room and normally they waited if the resident was in the dining room. She stated that this was done for privacy and resident rights because doing any type of patient care in open areas lacked privacy.On 3/5/2026 at 12:32 PM, an interview was conducted with certified nursing assistant #1 who stated that most of the time the nurses did the vital signs themselves. She stated that if she were doing any vital signs they would be done in the residents room not out in the public areas.The facility provided policy, Resident Rights and Facility Responsibility revised 10/7/25 documented in part, It is the facility's policy to comply with all Resident Rights .On 3/5/2026 at approximately 3:03 PM, administrator #2, administrator #3, the director of nursing, the regional director of clinical services, the regional director of operations, the infection preventionist and the administrator in training were made aware of the findings. No further information was provided prior to exit.

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	495431	A. Building B. Wing	03/05/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview facility document review and clinical record review, it was determined the facility staff failed to develop/implement the care plan for three of 36 residents in the survey sample, Resident #6, Resident #4 and Resident #43.The findings include:1.The facility staff failed to develop the comprehensive care plan for fluid restriction for Resident #6 (R6). R6 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CVA (cerebrovascular accident), CHF (congestive heart failure), pneumonitis and chronic respiratory failure. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/13/26, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the comprehensive care plan dated 1/8/26 revealed, PROBLEM: The resident has impaired cardiovascular status related to CHF. APPROACH: Monitor/ document/ report any signs/symptoms of congestive heart failure: dependent edema of legs and feet, SOB (shortness of breath) upon exertion, cool skin, dry cough, distended neck veins, weakness and weight gain unrelated to intake. A review of the physician orders dated 1/13/26 revealed, Fluid restriction 1500 milliliters (mL)/24 hours (hrs). 1500cc Fluid Restriction: Dietary to give 960mL (BREAKFAST 480mL, LUNCH 240mL, DINNER 240mL). Nursing to give up to 540mL/24hr (day SHIFT 180mL, evening SHIFT 180mL, night SHIFT 180mL). A review of the January, February and March 2026 MARs (medication administration record) revealed fluid restriction provided as ordered. Observations on 3/4/26 breakfast and 3/5/26 lunch revealed R6 on fluid restriction as ordered. On 3/5/26 at 8:05 AM, an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 described the care plan as a document with the purpose of detailing the plan for the residents and providing care to the resident. The care plan should be developed and implemented for resident safety. Fluid restrictions should be on the care plan, because it is resident safety and the CNAs (certified nursing assistants) do not have access to the MAR (medication administration record) which is where the nurses document the fluid restriction. On 3/5/26 at 2:30 PM, the administrator and the director of nursing were informed of the concern. According to the facility's Comprehensive Care Plan policy, which revealed, The facility will develop a comprehensive person-centered care plan for each resident that includes measurable goals and timetable to meet the resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment. These plans will be focused on resident choices and abilities with the intent of maintaining or improving resident functional abilities and quality of life. The care plan is reviewed on an ongoing basis and revised as indicated by the resident's needs, wishes or change in (continued on next page)

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	495431	A. Building B. Wing	03/05/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition. In additional problem areas are identified not triggered by the MDS, the care plan will be updated to reflect these area(s). No further information was provided prior to exit. 2. For Resident #4 (R4), the facility staff failed to implement the resident's comprehensive care plan for bilateral floor mats. R4's comprehensive care plan dated 11/19/25 documented, Resident has had an actual fall and is at risk for fall r/t (related to) muscle weakness/other reduced mobility/osteoarthritis, psychotropic med use, incontinence, impaired safety awareness/dementia. Bilateral floor mats. On 3/3/26 at 2:02 p.m., and 3/4/26 at 8:38 a.m., R4 was observed lying in bed. A floor mat was observed on the left side of the bed. No floor mat was observed on the right side of the bed. The mat was observed rolled up, against the wall, in the corner of the room. On 3/5/26 at 12:30 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #4. LPN #4 stated the care plan is basically an outline of care; the best plan of care for that resident and the goals that staff are trying to accomplish while the resident is at the facility. LPN #4 stated that when a care plan documents bilateral floor mats, a mat should be on the floor, on each side of the bed, while the resident is in bed. On 3/5/26 at 3:08 p.m., Administrator #2 and the Director of Nursing were made aware of the above concern. No further information was presented prior to exit. 3. For Resident #43, (R43) the facility staff failed to implement the comprehensive care plan for care of a urinary catheter bag (1). R43 diagnoses include but were not limited to retention of urine (2), neuromuscular dysfunction of bladder (3), obstructive and reflux uropathy (4). The most recent MDS (minimum data set) quarterly assessment with an ARD (assessment reference date) of 1/15/26 documented R43 having an indwelling catheter for urinary retention, neuromuscular dysfunction of bladder and obstructive and reflux uropathy. A review of the comprehensive care plan dated 10/27/25 revealed, PROBLEM: The resident requires an indwelling urinary catheter related to urinary retention. Failed voiding trial 10/24/25. APPROACH: Do not allow tubing or any part of the drainage system to touch the floor. Observations failed to evidence positioning of catheter bag off the floor. On 3/4/26 at 8:53 AM an observation of R43's catheter bag on the floor. On 3/4/26 at 10:17 AM, R43 stated the staff changed his catheter bag however the catheter bag was observed touching the floor surface while R43 was lying in the bed with the bed in a low position. On 3/4/26 at 11:20 AM an observation was made of R43's catheter bag hanging on the left side of the bed. The bed was observed in the lowest position, and the catheter bag was observed touching the (continued on next page)

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	495431	A. Building B. Wing	03/05/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	floor surface. 03/04/2026 at 2:17 PM an interview was conducted with RN (registered nurse) #1. RN#1 stated that in order to maintain foley catheter bags they were placed below the level of the bladder; they place a privacy bag over them and clean the area daily. RN#1 further stated catheter bags should not be on the floor for infection control. On 3/5/2026 at 10:30AM ADM (administrator) #2, Director of Nursing, IP/ADON (infection preventionist/assistant director of nursing) and the regional director of operations were notified of the findings. No further information was provided prior to exit. References: A urinary catheter is a tube placed in the body to drain and collect urine from the bladder. https://medlineplus.gov/ency/article/003981.htm Urinary retention is a condition in which you cannot empty all the urine from your bladder. https://www.niddk.nih.gov/health-information/urologic-diseases/urinary-retention Neurogenic bladder is a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition. https://medlineplus.gov/ency/article/000754.htm Obstructive uropathy is a condition in which the flow of urine is blocked. https://medlineplus.gov/ency/article/000507.htm

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	495431	A. Building B. Wing	03/05/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to follow professional standards of practice to promote residents highest level of well-being for one of eight residents in the medication observation sample, Resident #34.The findings include1. For Resident #34 (R34), the facility staff failed to follow professional standards of practice during medication administration.On 3/4/2026 at 8:29AM, an observation was made of registered nurse (RN) #1 preparing medication for R34. RN#1 was observed crushing one 40 mg (milligrams) pantoprazole (1) tablet, delayed release and administered it to R34.Review of the physician orders for R34 document in part, Pantoprazole tablet, delayed release (DR/EC) (delayed released/enteric coated); 40 mg; Amount 1 tab oral once a day. Start Date 10/27/25. On 03/05/2026 at 8:18 AM, an interview was conducted with LPN (licensed practical nurse) #3, who stated that the process for administering crushed medication is to review the eMAR (electronic medical administration record) and check for orders to crush the medication. She further stated that she verifies if a medication can be crushed and that she crushes each medication separately and places it in a cup with applesauce. She stated that she informs each residents what medications she has given them and educate them as needed. LPN #3 stated if a medicine cannot be crushed and the resident cannot swallow the medication without it being crushed, she would reach out to the doctor to see if there is a liquid form of the medication or another substitute medication for the resident. On 03/05/2026 at 9:37 AM, an interview was conducted with the pharmacist who stated that extended-release pantoprazole should not be crushed as it can change the medication. When asked if there are any potential adverse side effects, stated I don't think there would be any side effects but the effectiveness of the medication may be less. The pharmacy provided document Common Oral Dosage Forms That Should Not be Crushed, dated 2024, has pantoprazole listed as one.On 3/5/2026 at 10:30AM, Administrator #2, Director of Nursing, IP/ADON (infection preventionist/assistant director of nursing) and the regional director of operations were notified of the findings. No further information was provided prior to exit.No further information was provided prior to exit.Reference:Pantoprazole is used to treat damage from gastroesophageal reflux disease. Pantoprazole comes as a delayed-release (releases the medication in the intestine to prevent break-down of the medication by stomach acids) tablet and as delayed-release granules to take by mouth. https://medlineplus.gov/druginfo/meds/a601246.html

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495431	A. Building B. Wing	03/05/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, staff interview and clinical record review, the facility staff failed to implement fall precautions for one of 36 residents in the survey sample, Resident #4. For Resident #4 (R4), the facility staff failed to implement fall mats on both sides of the bed when the resident was in bed. On 3/3/26 at 2:02 p.m., and 3/4/26 at 8:38 a.m., R4 was observed lying in bed. A floor mat was observed on the left side of the bed. No floor mat was observed on the right side of the bed. The mat was observed rolled up, against the wall, in the corner of the room.R4's comprehensive care plan dated 11/19/25 documented, Resident has had an actual fall and is at risk for fall r/t (related to) muscle weakness/other reduced mobility/osteoarthritis, psychotropic med use, incontinence, impaired safety awareness/dementia. Bilateral floor mats.On 3/5/26 at 12:30 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #4. LPN #4 stated that when a care plan documents bilateral floor mats, a mat should be on the floor, on each side of the bed, while the resident is in bed.On 3/5/26 at 3:08 p.m., Administrator #2 and the Director of Nursing were made aware of the above concern.No further information was presented prior to exit.

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to maintain a catheter bag in a sanitary manner for one of 36 residents in the survey sample, Residents #43.The findings include:1. For Resident #R43 (43), the facility staff failed to prevent the catheter bag from resting on the floor surface. R43 diagnoses include but were not limited to retention of urine (1), neuromuscular dysfunction of bladder (2), obstructive and reflux uropathy (3).On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/15/26, R43 scored 13 out of 15 on the BIMS (brief interview for mental status). Section H Bladder and Bowel code R43 as having an indwelling catheter for urinary retention, neuromuscular dysfunction of bladder and obstructive and reflux uropathy. On 3/4/26 at 8:53 AM R43's catheter bag was observed touching the floor. R43 stated it was leaking and he had informed staff about 15 minutes ago. On 3/4/26 at 10:17 AM, R43 states staff changed the catheter bag. The catheter bag was observed touching the floor surface on the left side of the bed while R43 was lying in the bed in the lowest position. On 3/4/26 at 11:20 AM an observation was made of R43's resident's catheter bag hanging on the left side of the bed. The bed was observed in the lowest position, and the catheter bag was observed touching the floor surface.The physician's order for R43 documented in part Catheter Care: Foley Catheter: Indicate size (16F) (French) and balloon size (10ml). DX (diagnosis): Urinary retention secondary to obstructive uropathy. Order Dated 2/28/26 A review of the comprehensive care plan dated 10/27/25 revealed, PROBLEM: The resident requires an indwelling urinary catheter related to urinary retention. Failed voiding trial 10/24/25. APPROACH: Do not allow tubing or any part of the drainage system to touch the floor.On 03/04/2026 2:17 PM an interview was conducted with RN#1 who stated to maintain catheter bags they are placed below the level of the bladder, privacy bag are placed over them and they clean the area daily. Bags should not be on the floor for infection control. RN #1further stated they keep R43 bed in a low position because of his fall risk. She stated she will talk to the manager about positioning the bag.The facility's policy Indwelling Urinary Catheter Care Procedure documented in part, 10. The urinary drainage bag must be placed below the bladder level but not on the floor.On 3/5/2026 at 10:30AM Admin (administrator) #2, Director of Nursing, IP/ADON (infection preventionist/assistant director of nursing) and the regional director of operations were notified of the findings. No further information was provided prior to exit.References:1. Urinary retention is a condition in which you cannot empty all the urine from your bladder. https://www.niddk.nih.gov/health-information/urologic-diseases/urinary-retention2. Neurogenic bladder is a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition. https://medlineplus.gov/ency/article/000754.htm3. Obstructive uropathy is a condition in which the flow of urine is blocked. https://medlineplus.gov/ency/article/000507.htm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495431	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to honor a food allergy for one of 36 residents in the survey sample, Resident #15. The findings include:For Resident #15 (R15), the facility staff failed to honor the resident's pineapple allergy on 11/27/25. A review of R15's clinical record revealed the resident was allergic to pineapple. On R15's admission minimum data set assessment, with an assessment reference date of 9/10/25, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 3/3/26 at 2:06 p.m., an interview was conducted with R15. R15 stated the resident was allergic to pineapple and displayed a meal ticket that documented the resident was allergic to pineapple. R15 stated that on Thanksgiving (11/27/25), the facility cooked ham with pineapple, removed the pineapple, and served the ham to the resident. On 3/4/26 at 8:26 a.m., an interview was conducted with the Dietary Manager. The Dietary Manager stated R15 was served ham that was cooked with pineapple on Thanksgiving Day. The Dietary Manager stated that on that day, the ham was cooked with pineapple rings then the pineapple rings were discarded before R15 was served. The Dietary Manager stated R15's ham should have been cooked separately but the cook did not think about it. The Dietary Manager stated he educated staff regarding this. On 3/5/26 at 3:08 p.m., Administrator #2 and the Director of Nursing were made aware of the above concern. The facility food allergies policy documented, Individuals with food allergies will be provided with safe foods and fluids, and appropriate substitutions to maintain health. No further information was presented prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495431	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berea Health & Rehab Center	55 Brimley Drive 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review, it was determined that the facility staff failed to administer a vaccine for one of five residents in the immunization record review, Residents # 27. The findings include:For Residents # 27 (R27) the facility staff failed to administer the pneumococcal vaccine (1). On the most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of [DATE], R27 was coded as having both short- and long-term memory difficulties and was coded as being severely cognitively impaired for making daily decisions. The EHR (electronic health record) for R27 documented in part, Preventative Health. Pneumococcal - [DATE] education provided. Note: Education on risks/benefits/alternative reviewed via (by) pneumococcal VIS (vaccine information sheet) with resident. Resident verbalized understanding. RP (responsible party) contacted via phone. Consent obtained from resident and RP. Further review failed to evidence that R27 received the pneumococcal vaccine was administered. On [DATE] at approximately 11:00 a.m. an interview was conducted with the Assistant Director of Nursing (ADON) regarding the pneumococcal vaccination for R27. She was asked to describe the procedure for documenting when the pneumococcal vaccine is administered to a resident. She stated when the vaccine is administered, the date it was given, and the lot number of the vaccine(s) is documented in the resident's electronic health record under preventative health. She stated they were unable to locate documentation of when R27 received the pneumococcal vaccine. She further stated that R27's spouse was contacted by telephone and stated that she recalled that R27 had received the vaccinations at the facility. The ADON also stated at the time R27 was scheduled to receive the pneumococcal vaccine, there was a batch of vaccines that had expired and it was already documented in R27's record that consent was given and education was provided regarding the pneumococcal vaccine, the date R27 received the vaccine was not documented. On [DATE] at approximately 3:04 p.m., the Administrator # 2 and the Director of Nursing, were made aware of the findings. No further information was presented prior to exit. References:(1) Can prevent pneumococcal disease. Pneumococcal disease refers to any illness caused by pneumococcal bacteria. These bacteria can cause many types of illnesses, including pneumonia, which is an infection of the lungs. Pneumococcal bacteria are one of the most common causes of pneumonia. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a610017.html.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495431	A. Building B. Wing	03/05/2026

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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 - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review, it was determined that the facility staff failed to administer a vaccine for one of five residents in the immunization record review, Residents # 27. The findings include:For Residents # 27 (R27) the facility staff failed to administer the COVID-19 vaccine (1). On the most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of [DATE], R27 was coded as having both short- and long-term memory difficulties and was coded as being severely cognitively impaired for making daily decisions. The EHR (electronic health record) for R27 documented in part, Preventative Health. COVID-19 - [DATE] education provided. Education on risks/benefits/alternative reviewed via (by) Covid-19 VIS (vaccine information sheet) with resident. Resident verbalized understanding. RP (responsible party) contacted via phone. Consent obtained from resident and RP. Further review failed to evidence that R27 the COVID-19 vaccine was administered. On [DATE] at approximately 11:00 a.m. an interview was conducted with the Assistant Director of Nursing (ADON) regarding the COVID-19 vaccination for R27. She was asked to describe the procedure for documenting the COVID-19 vaccine when it is administered to a resident. She stated when the vaccine is administered, the date it was given, and the lot number of the vaccine(s) is documented in the resident's electronic health record under preventative health. She stated they were unable to locate documentation of when R27 received the COVID-19 vaccine. She further stated that R27's spouse was contacted by telephone and stated that she recalled that R27 had received the vaccination at the facility. The ADON also stated at the time R27 was scheduled to receive the COVID-19 vaccine, there was a batch of vaccines that had expired and it was already documented in R27's record that consent was given and education was provided regarding the COVID-19 vaccine, the date R27 received the vaccine was not documented. On [DATE] at approximately 3:04 p.m., the Administrator # 2 and the Director of Nursing, were made aware of the findings. No further information was presented prior to exit. References:(1) Used to prepare the body's immune system to protect against COVID-19. COVID-19 vaccines have been shown to do a very good job of: Preventing infection with the SARS-CoV-2 virus, which causes COVID-19, protecting against serious illness, hospitalization, and death from COVID-19 and reducing the risk of people spreading COVID-19. This information was obtained from the website: https://medlineplus.gov/ency/article/007775.htm.