STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kempsville Health & Rehab Center	5520 Indian River Road Virginia Beach, VA 23464

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, document review and facility policy review, the facility failed to ensure allegations of staff-to-resident abuse were reported timely, and in accordance with federal reporting requirements, to the State Survey Agency (SSA) for one of four sample residents (Resident (R) 101) reviewed for allegations of abuse or neglect. The facility's failure to promptly report allegations of abuse limited regulatory oversight and had the potential to delay protective interventions for residents.Findings include:Review of R101's undated Face Sheet located in the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnoses of dementia with behavioral disturbances, restlessness and agitation, and bipolar disorder. R101 passed away on 10/18/25.Review of R101's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/29/25, located in the EMR revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired. Review of the facility reported incident (FRI) submitted to the state survey agency (SSA), dated 05/12/25 revealed, [R101] stated to the Director of Nursing (DON) on 05/12/25 at 7:00 AM .last night [05/11/25] certified nursing assistant (CNA) 1 grabbed her hand and hit her face. Continued review of the FRI revealed an incident on 05/11/25 at approximately 10:00 PM when R101 became combative and displayed physical and verbal aggression during care with CNA1. Further review of the FRI revealed R101 sustained a skin tear to her right fourth finger and a bruise under right eye/cheekbone area. Review of the facility investigation file for the incident that occurred on 05/11/25 revealed that CNA1 reported the combative episode with R101 to Registered Nurse (RN) 1 at approximately 10:00 PM. CNA1 stated that R101 had grabbed her wrist and while pulling her hand back from R101, that R101 sustained a skin tear. Continued review of the FRI revealed R101 stated to RN1, .staff (CNA1) had punched her. RN1 notified Licensed Practical Nurse (LPN) 2 of the incident and allegation made by R101 at approximately 10:15 PM. LPN2 stated to RN1 that LPN2 would notify the DON regarding the incident and allegation of abuse. Further review of the FRI revealed LPN2 did not notify the DON on 05/11/25. The DON became aware of the incident on 05/12/25 at 7:00 AM.During an interview on 02/26/26 at 12:45 PM, RN1 confirmed R101 had been combative, and physically aggressive with CNA1 during care on 05/11/25. RN1 also stated LPN2 informed her she would notify the DON. RN1 stated she put CNA1's statement and her statement under the DON's door at the end of her shift.Review of the FRI revealed the facility notified the SSA on 05/12/25 at 5:39 PM of the allegation of staff to resident abuse. During an interview on 02/26/26 at 2:00 PM, the DON stated that LPN2 did not notify her on 05/11/25 of the incident and allegation of abuse, and that she was informed on 05/12/25 at 7:00 AM. The DON confirmed that LPN2 should have notified her on 05/11/25 after R101 made the allegation of abuse. The DON also confirmed the initial notification to the SSA was 05/12/25 at 5:39 PM.Review of the facility's policy titled, Virginia Resident Abuse Policy revised 01/05/26, revealed, . All allegations of abuse, neglect, involuntary seclusion, (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injuries of unknown source and misappropriation of resident property must be reported immediately to the Administrator, DON and the applicable SSA. If the event that caused the allegation involves an allegation of abuse, it should be reported to the Department of Health (DOH) immediately, but not later than 2 hours after the allegation is made .

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and facility policy review, the facility failed to investigate a potential injury of unknown origin for one of four sample residents (Resident (R) 101) reviewed for allegations of abuse. The facility's failure to thoroughly investigate the injury had the potential to delay protective interventions for residents.Findings include:Review of R101's undated Face Sheet located in the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnoses of dementia with behavioral disturbances, restlessness and agitation, and bipolar disorder. R101 passed away on 10/18/25.Review of R101's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/29/25 located in the EMR with a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired. Review of the facility reported incident (FRI), submitted to the state survey agency (SSA), dated 05/12/25 revealed R101 stated to the Director of Nursing (DON) on 05/12/25 at 7:00 AM .last night (05/11/25) certified nursing assistant [CNA 1] grabbed her hand and hit her face. Continued review of the FRI revealed an incident on 05/11/25 at approximately 10:00 PM when R101 became combative and displayed physical and verbal aggression during care with CNA1. Further review of the FRI revealed that R101 sustained a skin tear to her right fourth finger and a contusion to the right cheek.Review of the facility's investigation file for the incident dated05/11/25 revealed that CNA1 reported to Registered Nurse (RN) 1 that during care R101 became combative and physically aggressive, had grabbed CNA1's wrist and while CNA1 was pulling her hand back from R101, that R101 sustained a skin tear. CNA1 did not mention an injury to the right cheekbone area. RN1 assessed R101, provided treatment to the skin tear, and completed a full body/skin assessment with no other skin impairments noted. RN1 observed a contusion to R101's right cheekbone area, asked R101 what happened and R101 stated .that girl [CNA1] punched her.Review of RN1's written statement of the incident on 05/11/25 revealed CNA1 stated to RN1 .[CNA1] could have hit her face during when she [R101] was swinging. RN1 further noted that R101 .some bruising and mild swelling to under the right eye at bony area.Review of CNA1's written statement of the incident dated05/11/25 revealed, .lay the bed down to reposition [R101], resident grabbed my arm and started to swing at me. I pulled back my arm and resident's hand obtained a skin tear from my watch. A second statement from CNA1 on 05/12/25 provided to the DON revealed, .I do not remember coming in contact with her face at any time. All I remember is her hands swinging.Review of Licensed Practical Nurse (LPN) 2's written statement of the incident on 05/11/25 revealed, .witnessed [R101] had a swollen and discolored right eye (under eye) .and [CNA1] was unaware if [R101's] own hand hit her in the face and [CNA1] did not know how the resident's face got bruised.Continued review of the facility investigation file revealed an undated document titled Abatement Plan: Abuse Allegation which stated, .during care by CNA1 the resident became combative and sustained skin tear and hit self, causing swelling to affected eye. RN1 assessed resident, who at the time reported she was punched in the face. No additional documentation was noted in the facility investigation file, or R101's EMR, that ruled out, or mentioned any facial bruising noted prior to the incident on 05/11/25 at approximately 10:00 PM or possible causes for the contusion on the right cheekbone area. Further review revealed all staff who worked on R101's unit on 05/11/25 were interviewed about the incident. The staff stated that they did not hear, or see, anything occur between CNA1 and R101 but were not specifically asked about the contusion to R101's cheek.During an interview on 02/26/26 at 12:45 PM, RN1 confirmed R101 had been combative, and physically aggressive with CNA1 during care on 05/11/25. RN1 stated she had not observed any bruising to R101's right cheekbone area prior to the incident.During an interview on 02/26/26 at 2:00 PM, the Administrator and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON) stated that they were able to clearly identify how the skin tear to R101's right fourth finger occurred but were unable to determine the exact cause of the right cheekbone contusion. The DON confirmed during the interview the possibility that either CNA1, while attempting to remove herself from R101's grasp, may have made contact with R101's right cheekbone area, or R101 could have hit herself, causing the contusion. The DON stated they were unable to establish how the right cheekbone contusion happened and confirmed the documentation was not specific. The DON also stated that during the reenactment of the incident, it was more focused on how the skin tear occurred and not the contusion to the right cheekbone.Review of the facility's policy titled, Virginia Resident Abuse Policy revised 01/05/26, revealed, .After completion of the investigation, all of the evidence should be analyzed, and the Administrator (or his/her designee) will make a determination regarding whether the allegation or suspicion is substantiated, and, for Injuries of Unknown Source, a determination regarding the probable source of the injury.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, and facility policy review, the facility failed to ensure that a person-centered baseline care plan was developed within 48 hours of admission, and provided to the resident or their representative, for five of five residents (Resident (R) 105, R113, R59, R67, and R100) out of 20 sampled residents. This failure to establish initial care instructions for nursing staff placed newly admitted facility residents at risk of not receiving critical care needs, and residents and representatives to be poorly informed of anticipated plans of care.Findings include:1. Review of R105's Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab indicated the resident was admitted to the facility on [DATE] and readmitted [DATE]. The document indicated the resident's diagnoses included displaced fracture of greater trochanter of left femur, muscle wasting and atrophy left lower leg, type two diabetes mellitus, cerebral infarction, and protein calorie malnutrition. R105 was discharged on 01/14/26.Review of R105's five day Minimum Data Set (MDS) Assessment with an assessment reference date (ARD) of 12/14/25 and located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Review of R105's admission Observation dated 12/08/25 and located under the Progress Notes tab revealed a Baseline Care Plan section for review with the resident that stated only that the resident would receive medications as ordered, skilled care, pain medications as ordered, skin care to prevent skin breakdown, dietary needs as ordered, and activities of daily living as necessary. Review of R105's Progress Notes dated 12/08/25 and located under the Progress Notes tab, revealed the resident was admitted with an indwelling urinary catheter and two post-operative surgical wounds to the left hip. The Baseline Care Plan failed to identify the indwelling urinary catheter and two surgical wounds.Review of R105's Baseline Care Plan Checklist dated 12/15/25 and located under the Resident Documents tab revealed the form was completed by the Social Service Director (SSD) on 12/15/25 and was documented to be due on 12/12/25. The Baseline Care Plan Checklist was signed by the resident on 12/15/25. Review of R105's Comprehensive Care Plan, dated 12/23/25 and located in the EMR under the Care Plan tab, revealed R105's foley catheter was not identified in any care planning until it was initiated on 12/23/25. Review of R105's Comprehensive Care Plan, dated 01/05/26 and located in the EMR under the Care Plan tab, revealed R105's skin integrity was not identified in any care planning until it was initiated on 01/05/26.2. Review of R113's Face Sheet located under the Face Sheet tab of the EMR indicated the resident was admitted to the facility on [DATE] with diagnoses of non-traumatic acute subdural hemorrhage, nondisplaced fracture of greater tuberosity of right humerus, dysphagia, type two diabetes mellitus with hyperglycemia, protein calorie malnutrition, and dementia.Review of R113's admission MDS with an ARD of 02/23/26 and located in the EMR under the MDS tab revealed a BIMS score of eight out of 15, which indicated the resident was moderately cognitively intact. Review of R113's admission Observation dated 02/17/26 and located under the Progress Notes tab revealed a Baseline Care Plan section for review with the resident that stated only that the resident would receive medications as ordered, skilled care, pain medications as ordered, skin care to prevent skin breakdown, dietary needs as ordered, and activities of daily living as necessary. Review of R113's Progress Notes dated 02/17/16 and located under the Progress Notes tab, revealed the resident was admitted with a nondisplaced fracture of the right humerus, and a fall with head injury including a neurosurgery recommendation for a soft collar at all times. The Baseline Care Plan failed to identify the fracture or the need for a soft collar after a significant head injury.Review of R113's Baseline Care Plan Checklist, dated 02/23/26 and located under the Resident Documents (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tab, revealed the form was completed by the SSD on 02/23/26, but was due on 02/21/26. The Baseline Care Plan Checklist was signed by the resident representative on 02/23/26. Review of R113's Comprehensive Care Plan, located in the EMR under the Care Plan tab, revealed R113's fall and humerus fracture were not identified in any care planning until it was initiated on 02/20/26. During an interview on 02/23/26 at 1:02 PM, R113 stated that they did not recall talking to any staff member about their care, or what was going to happen going forward. R113 did not recall anyone keeping them informed about their care needs.3. Review of R59's Face Sheet, located in the EMR under the Face Sheet tab indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnoses included displaced transverse fracture of right patella, protein calorie malnutrition, post-traumatic stress disorder, anxiety, major depressive disorder, and acquired absence of right upper limb.Review of R59's five day MDS with an ARD of 02/11/26 and located in the EMR under the MDS tab revealed a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of R59's admission Observation dated 02/05/26 and located under the Progress Notes tab revealed a Baseline Care Plan section for review with the resident that stated only that the resident would receive medications as ordered, skilled care, pain medications as ordered, dietary needs as ordered, and activities of daily living, as necessary. Under Skin it stated that skin issues were present, and to see Order/Observations, not attached to the document provided to the resident.Review of R59's Progress Notes dated 02/05/26 and located under the Progress Notes tab, revealed the resident was admitted with a surgical incision to right knee with four to five sutures and slough tissue present, wound vac applied. R59 was also admitted with a physician order for Cefazolin 2-gram reconstituted solution, to be administered intravenously. The Baseline Care Plan failed to identify the surgical wound with the wound vac or the intravenous antibiotic.Review of R59's Baseline Care Plan Checklist, dated 02/11/26 and located under the Resident Documents tab, revealed the form was completed by the SSD on 02/11/26, but was due on 02/09/26. The Baseline Care Plan Checklist was signed by the resident on 02/11/26. Review of R59's Comprehensive Care Plan located in the EMR under the Care Plan tab revealed R59's antibiotic and wound vac usages were not identified in any care planning until it was initiated on 02/16/26. 4. Review of R67's Face Sheet located in the EMR under the Face Sheet tab indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnoses included neoplasm of unspecified behavior of brain, protein calorie malnutrition, hemiplegia affecting right dominant side, and bipolar disorder. Review of R67's five day MDS with an ARD of 02/05/26 and located in the EMR under the MDS tab revealed a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of R67's admission Observation dated 01/30/26 and located under the Progress Notes tab revealed a Baseline Care Plan section for review with the resident that stated only that the resident would receive medications as ordered, skilled care, pain medications as ordered, dietary needs as ordered, and activities of daily living, as necessary. Specific care needs including antipsychotic, hypnotic, and antidepressant medications ordered upon admission were not identified.Review of R67's Baseline Care Plan Checklist, dated 02/04/26 and located under the Resident Documents tab, revealed the form was completed by Social Service (SS)1 on 02/04/26, but was due on 02/03/26. The Baseline Care Plan Checklist was signed by the resident on 02/04/26. Review of R67's Comprehensive Care Plan located in the EMR under the Care Plan tab revealed R67's usage of hypnotic, antipsychotic, and antidepressant medications were not identified in any care planning until they were initiated on 02/13/26. During an interview on 02/23/26 at 1:10 PM, R67 said that they had been at the facility for approximately a month. R67 stated that they were not aware of their plan of care and said that no one had sat down with them and gone over specific things about their care, and (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan for discharge.5. Review of R100's Face Sheet, located in the EMR under the Face Sheet tab, indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnoses include acute kidney failure, protein calorie malnutrition, sepsis, and spinal stenosis. R100 was discharged on 12/28/24.Review of R100's five day MDS with an ARD of 12/18/24 and located in the EMR under the MDS tab revealed a BIMS score of 14 out of 15, which indicated the resident was cognitively intact. Review of R100's admission Observation, dated 12/12/24 and located under the Progress Notes tab revealed a Baseline Care Plan section for review with the resident that stated only that the resident would receive medications as ordered, skilled care, pain medications as ordered, dietary needs as ordered, and activities of daily living, as necessary. Under Skin it states that skin issues were present, and to see Order/Observations not attached to the document provided to the resident. Specific care needs including antidepressant medications ordered upon admission were not identified.Review of R100's Progress Notes, dated 12/12/24 and located under the Progress Notes tab, revealed the resident was admitted with wounds noted to sacrum, left and right buttocks.Review of R100's Baseline Care Plan Checklist, dated 12/18/24 and located under the Resident Documents tab, revealed the form was completed by the SSD on 12/18/24, but was due on 12/16/24. The Baseline Care Plan Checklist was signed by the resident representative on 02/18/26. Review of R100's Comprehensive Care Plan, located in the EMR under the Care Plan tab, revealed R100's antidepressant medication usage and pressure wounds were not identified in any care planning until they were initiated on 12/19/24. During an interview on 02/26/26 at 9:05 AM, Social Service (SS) 1 said that the facility liked to have a newly admitted resident start therapy services before they had a care conference, which they called a Path meeting. SS1 stated that the Path documents would show who attended the meeting and received the care planning information.During an interview on 02/26/26 at 10:41 AM, Director of Rehab (DOR) confirmed that upon admission the resident would be evaluated, a plan of care would be established, and treatment would start. DOR said that the facility would have a care plan meeting with the resident and representative within the first three to five days and let the resident or representative know then what was needed to be worked on so they could get home.During an interview on 02/26/26 at 1:45 PM, Licensed Practical Nurse (LPN)1 confirmed R59 had been admitted to the facility with a wound vac. LPN1 said that when a resident was admitted to the facility, the nurse would do an initial observation assessment, which would be part of the baseline care plan. LPN1 said that the information at the bottom of the observation (pages 33-35), which included the Baseline Care Plan would be provided to the resident. LPN1 stated that the information documented in the assessment and Baseline Care Plan section was general information only and did not identify anything specific to the residents' care needs. LPN1 confirmed that it was at the Path meeting when specific care needs would be discussed with the residents or representatives, usually three to five days later.During an interview on 02/26/26 at 1:48 PM, SSD said that when a new resident was admitted , they did a general introduction to Social Services to the residents. SSD said that they did an initial assessment observation within 48 to 72 hours and documented it in the Observation tab in the EMR and then documented when it occurred on the Baseline Care Plan Checklist. SSD stated that the facility had a Path meeting within five days for short-term residents, after giving the resident two or three days of therapy to better understand the resident's status, therapy needs, and discharge process. SSD said that the residents and/or representatives were invited to the Path meeting. SSD said that starting with the initial assessment as the base and the discharge summary, they continued to develop the comprehensive care plan. SSD confirmed that different departments each put in their initial assessments for the baseline care plan within 48 to 72 hours. SSD said that they may see the residents right away, but if a resident (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was admitted on a Friday, it would be completed on a Monday. During an interview on 02/26/26 at 2:49 PM, Minimum Data Set Coordinator (MDSC) 2 stated that the baseline care plan was completed when the floor nurse documented their initial observations. MDSC2 said that the nurse would complete the initial observations daily, except when a resident was admitted on a Friday, which would mean the documentation would be completed on the following Monday. She said that the comprehensive care plan for a resident was developed within seven days of the MDS. MDSC2 said that the baseline care plan was the resident's basic care, which would include activities of daily living. She stated that the facility would add to the baseline care plan after they admit and then use it to develop the comprehensive care plan. She was not aware if specialty care needs would be included in a baseline care plan. During an interview on 02/26/26 at 4:25 PM, the Director of Nursing (DON) stated that the baseline care plan was attached to the initial nursing observation when a resident was newly admitted . The DON confirmed that the initial documented information was not resident specific. She said that the facility staff met with the resident and/or representative with the developed baseline care plan approximately three to five days after admission during the Path meeting. She confirmed the developed baseline care plan was not specific to resident care needs and was not provided in a timely manner to the resident or representative.Review of the facility's undated policy titled, Baseline Care Plan Protocol Checklist indicated, The Baseline Care Plan Protocol Checklist will trigger to be completed for all new admissions within the electronic chart system. Social Services or designee will check off each completed item, save, sign, and lock the assessment.A list of the resident's medications, therapy orders, and dietary instructions.print out orders.Social Service Recommendations Documentation.48 hour Interim/Baseline Care Plan.Social Services will bring the checklist to the Advance Care Planning meeting, and present one copy of all items to the resident/representative.Document on the Checklist the date the documentation was received by resident/representative.Review of the facility's policy titled, Comprehensive Care Planning Policy last reviewed 02/24/26 indicated, An interdisciplinary plan of care will be established and updated as indicated for every resident in accordance with state and federal regulatory requirements.An Interim baseline care plan will be developed within 48 hours of admission to ensure the resident's needs are met until the comprehensive care plan is completed.