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

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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 (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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 (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and review manufacturer's instructions for use, the facility failed to maintain a medication error rate below five percent. Out of the 27 opportunities for error, two errors occurred during medication administration with one of one Licensed Practical Nurse (LPN)3. The facility's medication error rate was 7.41%.Findings include:Observation of medication pass on the 400 unit the facility on 02/26/26 revealed the following medication errors:During medication administration with LPN3 on 02/26/25 at 09:01 AM, LPN3 injected 48 units of Lantus (Insulin Glargine - long-acting insulin) using an insulin pen into R110's abdomen and withdrew the insulin pen immediately.During an interview on 02/26/25 at 09:02 AM, LPN3 stated she was unaware of the manufacturer's instructions for use for the insulin pen and how long she was to hold the pen in the patient's body after injecting the medication before withdrawal.On 02/26/25 at 9:10 AM, LPN3 injected one unit of fast acting insulin Novolog Aspart using an insulin pen in R69's abdomen and retracted the insulin after one second.During an interview on 02/26/26 at 9:29 AM, LPN3 was told of the observation, and stated she had counted one to five quickly before withdrawing the injection from R69. LPN3 restated that she was unaware of how many seconds the manufacturer recommends to hold the pen for the patient to get the full dose.During an interview on 02/26/26 at 9:33 AM, the Licensed Practical Nurse (LPN)1 stated it was her expectation that LPN3 follow manufacturer's instructions for use for insulin pens. Review of Manufacture's IFU for the insulin pen titled INSTRUCTIONS FOR USE (insulin aspart-) injection, for subcutaneous use located at https://assets.bioconbiologics.com/asset/225989342563/document_9rdh45bfbl1jr4dbes9j89mb2n/ASP-2025-0 revealed:Giving the injectionI. Insert the needle into your skin. Inject the dose by pressing the push-button all the way in until the 0 lines up with the pointer (see diagram I). Be careful only to push the button when injecting.J. Turning the dose selector will not inject insulin. Keep the needle in the skin for at least 6 seconds and keep the push-button pressed all the way in until the needle has been pulled out from the skin . This will make sure that the full dose has been given.During an interview with the Director of Nursing (DON)on 02/26/26 at 4:35 PM, the DON stated it was her expectation that staff follow the manufacturer's instructions for use for medication injections.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and review of facility policy, the facility failed to ensure that two of two residents' insulin pens (Resident (R) 110 and R69) were labeled with the date they were opened. This failure had the potential for medications to be administered past their use by date and affect the residents' quality of life.Findings include:Observation during medication administration on [DATE] at 9:00 AM, Licensed Practical Nurse (LPN)3 withdrew an insulin pen of Lantus (Insulin Glargine - long-acting insulin) from the medication cart for R110. The pen had a bright pink label on the base indicating good for 28 days. Interview on [DATE] at 9:04 AM, when asked when the insulin pen was first opened and used, LPN3 stated she did not know the open date, but she just knew it was good for 28 days. LPN3 confirmed the opened date was not written on the pen.Observation on [DATE] at 9:09 AM, LPN3 pulled an insulin pen of fast acting insulin (Novolog Aspart) from the medication cart for R69. The insulin pen was marked as good for 28 days but did not have an open date. LPN3 acknowledged the pen did not have an open date, and stated R69 was admitted on [DATE], so that must be the open date. LPN3 proceeded to mark the insulin pen with an open date of [DATE].During an interview on [DATE] at 9:33 AM, LPN1 stated it was her expectation that insulin pens should be marked with the date they are first opened and the last date of use per pharmacy and manufacturer instructions for use.During an interview on [DATE] at 2:20 PM, the Infection Preventionist (IP) stated it was her expectation that medications are not given beyond the use by dates and should be labeled with the opened and expiration dates.During an interview on [DATE] at 4:35 PM, the Director of Nursing (DON) stated it was her expectation that medications should be appropriately labeled.Review of the facility's policy titled Storage and Expiration Dating of Medications and Biologicals dated [DATE], revealed:.10. Facility should ensure medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier.11. Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (i.e., vial, bottle, inhaler) when the medication has a shortened expiration date once opened or opened.11.1 Facility staff may record the calculated expiration date based on date opened on the primary medication container.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews and policy review, the facility failed to follow appropriate infection prevention practices for two of six residents (Resident (R) 69 and R110) observed during medication administration. This failure had the potential to expose the residents to contaminants in the environment.Findings include:Observation during medication administration on 02/26/25 at 09:01 AM, Licensed Practical Nurse (LPN)3 pierced the rubber septum of an insulin syringe without first cleaning the pen hub. LPN3 donned a gown and a pair of gloves without first performing hand hygiene and entered R110's room to give medications. LPN3 stated R110 was on contact precautions for Methicillin-resistant Staphylococcus Aureus (MRSA). On 02/26/25 at 9:03 AM, after administering R110's medication, LPN3 removed her gown and gloves, discarded them, and exited R110's room without performing hand hygiene. LPN3 returned to her medication cart, did not perform hand hygiene, reached into her pocket to retrieve the cart keys, touched her computer keyboard and mouse, and began to retrieve medications for the next resident.Observation on 02/26/25 at 9:04 AM, LPN3 retrieved medications for R69. LPN3 donned a pair of gloves without first performing hand hygiene and entered R69's room and used a glucometer to obtain R69's blood sugar level. However, was unable to obtain sufficient amount of blood from the finger to use the glucometer. LPN3 removed her gloves and exited R69's room without performing hand hygiene.Observation on 02/26/25 at 9:06 AM, LPN3 donned a pair of gloves to recheck R69's blood sugar. When this was completed, LPN3 removed her gloves, and returned to her medication cart. LPN3 did not perform hand hygiene.Observation on 02/26/25 at 9:10 AM, LPN3 applied a needle to an insulin pen without cleaning the hub of the pen. LPN3 donned a pair of gloves, gave the insulin medication per the insulin pen to R69, removed her gloves, and exited R69's room without performing hand hygiene. During an interview on 02/26/26 at 9:29 AM, LPN3 was told of the foregoing observations, and confirmed that she had failed to perform hand hygiene before donning gloves, in between glove changes, before and after entering residents' rooms, and from one resident's room to another. LPN3 acknowledged she did not scrub the insulin pens before applying a needle to the pensDuring an interview on 02/26/26 at 9:33 AM, LPN1 stated it was her expectation that LPN3 should perform hand hygiene before and after glove changes, and between residents' rooms. LPN1 stated it was also her expectation that LPN3 would scrub the hub of insulin pens before use.During an interview on 02/26/26 at 2:20 PM the Infection Preventionist (IP) stated it was her expectation that nurses perform hand hygiene before and after glove changes, and before entry, and after exiting residents' rooms. Review of facility's policy titled Hand Hygiene Policy dated 02/18/2026 revealed:.PROCEDURE:Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices Before moving from work on a soiled body site to a clean body site on the same patient After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal.