STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495234	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Pointe Rehabilitation and Nursing	5580 Daniel Smith Road Virginia Beach, VA 23462

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews and a review of the clinical record, the facility staff failed to provide the necessary activities of daily living (ADLs) for 2 dependent residents (Resident #79 and Resident #10) of the 45 residents in the survey sample.The findings included: 1. Resident #79 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses included old stroke with residual right-sided weakness, GI bleed, and COPD. The significant change Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 11/12/2025, was coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 15 out of 15. This indicated that Resident #79's cognitive abilities for daily decision-making were intact. The resident had a care plan problem with a revision date of 6/08/2022, which stated that the resident has an ADL self-care performance deficit related to activity intolerance, confusion, fatigue, and CVA with right-sided hemiparesis. The goal had a revision date of 1/19/2026, and it stated that the resident will improve the current level of function in ADLs through the review date, 5/10/2026. Some of the interventions included TRANSFER: The resident requires Mechanical Lift (SIT-TO-STAND) with 2 staff assistance for transfers in/out of bed and 2 person assist for toileting. BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. DRESSING: Allow sufficient time for dressing and undressing. DRESSING: Assist the resident to choose simple comfortable clothing that enhances the resident's ability to dress self. An interview was conducted with Resident #79 on 2/19/26 at approximately 11:24 AM. Resident #79 stated that the night shift Certified Nursing Assistants (CNAs) give her a bed bath, dress her, and help her out of bed and into a wheelchair daily at 5:30 AM. Resident #79 stated that she is aware when she needs to toilet, but getting assistance in a timely manner is the problem. The resident also stated she wanted showers, not just bed baths. The resident stated that because she will not allow staff to put her on the shower bed, they say she refuses showers. The resident stated she requested use of the shower chair because if she showers in bed, her hair will get wet and revert from the styling she receives every two weeks. The resident stated she can sit on the shower chair, but the staff will not allow her. A review of Resident #79's shower schedule revealed that she is scheduled to shower on the 11:00 PM to 7:00 AM shift. The DON stated that only people who had no idea of the time of the day were to have showers on the 11:00 PM to 7:00 AM shift. The DON then revised her statement, saying the resident requested to be out of bed each morning between 5:00 AM and 6:00 AM, which is why she would receive her shower during the night shift. The DON further stated that the resident had never expressed a (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/23/2026
NAME OF PROVIDER OR SUPPLIER Cypress Pointe Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 5580 Daniel Smith Road Virginia Beach, VA 23462	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	desire not to shower on the shower bed because it would make her hair wet. The DON was dismissive of the resident's goals for her ADL care, and she failed to consider development interventions she could implement to assist the resident in showering in the shower chair to prevent her hair from getting wet while still achieving the resident's desire for showers. The resident also stated that she must always wait for two CNAs because she is required to transfer using a Hoyer lift. The resident stated that often with her bowels, she has to push greatly to expel them because she has to wait so long for assistance after the urge, and with urination, she frequently urinates in the incontinence brief by the time the staff comes to render her care. The resident stated her goal is to eliminate normally, sitting on the commode, not intentionally in a brief, or lying in bed for a bowel movement. The resident also stated that she is not offered toileting services throughout the day, every 2-3 hours, as she is told by the licensed nursing staff is the expectation. The resident further said she does not receive incontinence care until after lunch daily. The resident reiterated that she does not receive care for her bowels or bladder from 5:30 AM until after lunch daily. The resident adamantly stated that when she activates the nurses' call light, the staff answers it, comes in to hear what care she needs, and then tells her, I have to get someone to help me. The resident said the staff does not return for hours, usually not until after lunch. The resident further stated that when the staff finally provides incontinence care after lunch, the incontinence brief is so heavy that it plops, making a loud noise when they drop it into the trash bag on the floor. Resident #79 stated she is strong enough to use the sit-to-stand lift, but facility staff said she must transfer using the Hoyer lift for her and staff's safety. On 2/19/26 at 11:24 AM, an interview was conducted with the Ombudsman. He stated that he frequently receives calls from Resident #79 regarding her basic care for incontinence, bathing, toileting, and repositioning to maintain her dignity. The Ombudsman stated that the resident is fearful of the Hoyer, and the facility staff stated that it is necessary because many staff have been injured while attempting to transfer the resident without a Hoyer, as she pulls against them. An interview was conducted with CNA #4 on 2/22/26 at 1:35 PM. CNA #4 stated that she checks on Resident #79 throughout the day but does not provide incontinence care until after lunch, close to 1:00 PM. CNA #4 stated Resident #79 is not toileted because she uses a Hoyer lift for transfers. CNA #4 said she had never seen a special Hoyer pad in the facility, which was designed for toileting and showers. On 2/22/26 at approximately 4:45 PM, a final interview was conducted with the Administrator, DON, and the Regional Nurse Consultant. The above concern was addressed, and the facility's staff were given the opportunity to provide information they considered pertinent to the findings. The Administrator stated they had the special Hoyer pad in the facility for Resident #79 to use and documented interventions they had instituted to allow the resident to use the least-restrictive device for transfers, toileting, and showers, and to allow the resident the dignity she desired during transfers to obtain the services she desired. The facility staff failed to provide any documentation or interventions that they stated were offered to the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/23/2026
NAME OF PROVIDER OR SUPPLIER Cypress Pointe Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 5580 Daniel Smith Road Virginia Beach, VA 23462	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #10 was originally admitted to the facility 11/27/23 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included: Chronic Pain and Insomnia, unspecified. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 1/25/26, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated that Resident #10's cognitive abilities for daily decision making were intact. In sectionGG(Functional Abilities Goals), the resident was coded as dependent with shower/bathe self, toileting hygiene, lower body dressing, and putting on and taking off footwear. Requiring partial moderate assistance with personal hygiene, requiring set-up or clean-up assistance with oral hygiene, and coded as independent with eating. The person-centered care plan, revised on 1/15/24, read that Resident #10 has an ADL self-care performance deficit r/t COPD, obesity. The Goal for the resident was that the resident would improve their current level of function in ADLs. The Interventions for the resident included: Encourage the resident to use the bell to call for assistance and discuss with the resident/family/POA any concerns related to loss of independence, decline in function. 02/19/26 1:41 pm., during the initial tour an interview was conducted with Resident #10 concerning her care and treatment. The resident said that she doesn't get changed for hours and has to lie in her wetness, and it has been happening for about 1 1/2 weeks. We don't get changed, it takes 30 minutes to an hour before they check on me. I'll call my son and say, Baby, I'm wet. And he will call the nurse's station. On 2/22/26 at approximately 2:15 pm., a brief interview was conducted with Resident #10. Resident #10 said, I stayed wet from 11:00 pm last night until this morning after 7:00 am. On 2/22/26 at approximately 4:45 PM, a final interview was conducted with the Administrator, DON, and the Regional Nurse Consultant. The above concern was addressed, and the facility's staff were given the opportunity to provide information they considered pertinent to the findings.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record review, and review of facility documents, the facility staff failed to provide adequate supervision to prevent accidents for 1 of 45 residents (Resident #95), in the survey sample which constituted harm.The findings included: The facility staff failed to provide adequate supervision to ensure Resident #95 was safe from falling while providing activities of daily living (ADL) care which constituted harm.Resident #95 was no longer a resident of the facility; therefore, a closed record review was conducted. Resident #95 was admitted to the facility on [DATE] after a hospital stay. The resident's diagnoses included unspecified dementia without behavioral disturbance, major depressive disorder, and muscle weakness. Resident #95 was coded as rarely/never understood so there was no Brief Interview for Mental Status (BIMS) completed.A synopsis of an event dated 2/25/25 revealed that Resident #95 had a witnessed fall while a Certified Nursing Assistant (CNA) was providing activities of daily living (ADL) care. The CNA turned around to rinse a wash cloth and the resident rolled out of the bed on left side and fell to the floor. The resident was diagnosed with the following: a distal fibular fracture and tibial fracture.A review of section GG (Functional Abilities and Goals) dated 1/4/25 of Resident #95's Minimum Data Set (MDS) coded the resident as dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.A review of Resident #95's nurses note dated 2/25/25 at 1:00 PM read: Resident received in bed alert with eyes opened. Resident had a witnessed fall from bed. Resident was in bed receiving adl care via aid. Aid turned around for a second to rinse wash cloth and resident rolled out of bed onto left side, per aid. Aid called out from resident's room. Resident was assessed head to toe; small skin noted to left lower arm area. Vital signs taken, resident moved to safe position in bed with bed low and mats to bedside floor. Md made aware, um made aware, JFS Shakayla made aware. Risk management completed. No signs of distress at this time. No signs of pain nor facial grimacing at this time. Respirations even and unlabored. Will advise oncoming nurse.A review of Resident #95's nurses note dated 2/26/25 at 8:47 PM read: Perimeter overlay was placed on the resident's mattress.A review of Resident #95's nurses note dated 2/28/25 at 3:34 PM read: Supervisor on duty made aware and witnessed the resident's bilateral lower leg was swollen had a bruised on (R) anterior ankle. N/P on-call was called and recieved a New order- - Acetaminophen 325mg 2tabs PRN by mouth Q/6hrs. - X-ray on bilateral legs , Call and inform first the family or close relative/ if they will approved it since Resident was on comfort care.A review of Resident #95's nurses note dated 2/28/25 at 10:31 PM read: Resident's bilateral ankle swollen w/ bruised observed, and obviously Pt. in pain while doing ADL care. U/M aware and N/P on call informed. N/O for PRN Acetaminophen 325mg 2 tabs. by mouth to be given PRN at Q6/hr. X-ray was also ordered (bilateral ankle) r/t swollen, Conditionally informing family members/ near relative or hospice if they will allow it. Hospice called 8:20pm and awaiting for confirmation. Endorse to the next on-coming shift Nurse.A review of Resident #95's nurses note dated 3/3/25 at 6:53 AM read: Resident has edema and bruising to BLE, no s/s of distress at this time. Resident legs are elevated on pillows while in bed.A review of Resident #95's nurses note dated 3/3/25 at 4:02 PM read: This order is outside of the recommended dose or frequency. Morphine Sulfate (Concentrate) Solution 20 MG/ML *Controlled Drug* Give 5 milligram by mouth every 4 hours as needed for Pain - This dose fails a general dose range check based on drug inputs and/or the patient information provided. This drug`s dose should be adjusted based on renal function. Manual screening is (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	required.A review of Resident #95's nurses note dated 3/3/25 at 7:10 PM read: X-ray Technician in this facility to do x-ray of bi-lateral feet and ankle awaiting results.:A review of Resident #95's nurses note dated 3/3/25 at 7:56 PM read: Xray bilateral ankles and feet DX: h/o fall: new bruising and swelling STAT for h/o Fall: bruising/swelling X-Ray-done 5:20pm, Awaiting for results.A review of Resident #95's nurses note dated 3/4/25 at 7:23 AM read: LEFT FOOT AND LEFT ANKLE X-RAY RESULTS: ACUTE LOOKING FRACTURES OF DISTAL TIBIA AND FIBULA ARE NOTED WITH POSTERIOR AND MEDIAL ANGULATION. THIS WRITER CALLED ON CALL MALTC, NO ANSWERS, THIS WRITER LEFT DETAILED VOICEMAIL. LEADERSHIP MADE AWARE.A review of Resident #95's nurses note dated 3/4/25 at 7:38 AM read: ON CALL MALTC MADE AWARE AND MD [NAME] GAVE ORDER TO SEND TO ER. ORDER PLACED IN MAR. CHARGE NURSE AM SHIFT AND LEDERSHIP MADE AWARE.A review of Resident #95's nurses note dated 3/4/25 at 7:48 AM read: F/U Results Acute Fracture Left foot and ankle, Guardian JEWISH FAMILY SERVICES made aware.A review of Resident #95's nurses note dated 3/4/25 at 6:53 PM read: Resident was picked up by Fast Tract transportation to go to Sentara [NAME] Hospital for evaluation & treatment for fracture. JFS aware.A review of Resident #95's nurses note dated 3/5/25 at 3:15 AM read: This writer (Nurse name) called Sentara [NAME] Hospital. Per ER Nurse, Resident will be admitted Dx: B/L Tibial Fracture.A review of Resident #95's Radiology Results Report dated 3/4/25 at 12:37 AM read: Impression - There appears to be a fibular fracture.On 2/21/26 at 9:58 AM, an interview was conducted with Licensed Practical Nurse (LPN) #1. LPN #1 stated that the Certified Nursing Assistant (CNA) was in the resident's room performing ADL duties when the fall occurred. LPN #1 also stated that the CNA turned her back to rinse a washcloth, and the resident fell out of the bed onto the floor. LPN #1 further stated that the resident was dependent regarding care, and the CNA should not have left the bedside and allowed the patient to fall out of the bed. LPN #1 lastly stated that the CNA did not lower the bed while performing ADL care, and fall mats were not in use at the time.The Physician's Order Summary (POS) read, Devices: Floor Mats to the side of the bed while in bed for safety QS every shift for Safety r/t frequent falls with a start date of 4/11/2024.On 2/21/26 at 12:05 PM, an interview was conducted with the Minimum Data Set (MDS) Nurse. The MDS Nurse stated that due to Resident #95 being coded as dependent for Roll left and right: the ability to roll from lying on back to left and right side, and return to lying on back on the bed, the CNA needed to make sure the patient was in the middle of the bed and safe before turning her back. The MDS Nurse also stated that if a patient falls off the bed, it means the patient was not positioned safely. The MDS further stated that the CNA should have made sure she positioned Resident #95 safely before turning her back. On 2/21/26 at 12:40 PM, an interview was conducted with the Rehabilitation Manager. The Rehabilitation Manager stated that Resident #95 was totally dependent regarding ADL care and would not follow commands. The Rehabilitation Manager also stated that the CNA should have ensured the resident was in a safe position before turning her back while providing ADL Care.On 2/21/26 at 4:20 PM, an interview was conducted with the Director of Nursing (DON) and Administrator. The DON stated that when a resident is dependent, a CNA should provide total care. The DON also stated that the CNA turning her back to rinse the washcloth was a safety issue. A review of Post Fall Review documentation dated 2/25/2025 at 10:30 AM read: Description of Fall - Resident rolled from bed while aid was in the room with the patient providing ADL care.The facility's Fall Prevention and Management policy was presented on 2/22/26 at 10:17 AM by the Regional Nursing Consultant without an effective date. The policy read, Policy: It is the policy of this facility to provide resident-centered care that meets the psychological, physical, and emotional needs and concerns of the residents. Fall prevention and management is the process of identifying risk factors that can maximize the potential for falls, and also a process to manage a resident's care if a fall occurs. Fall Risk (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Assessment: Other factors should include the environment, medications, physical and mental diagnosis as well as the resident's current ADL status.On 2/22/26 at approximately 4:35 PM, a final interview was conducted with the Administrator, Director of Nursing, and Regional Nursing Consultant. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews and a review of the clinical record, the facility staff failed to provide appropriate treatment and services to assist Resident #79 to achieve as much bowel and bladder control as possible, for 1 of 45 in the survey sample. The findings included: Resident #79 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses included old stroke with residual right-sided weakness, GI bleed, and COPD. The significant change Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 11/12/2025, was coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 15 out of 15. This indicated that Resident #79's cognitive abilities for daily decision-making were intact.The resident had a care plan problem with a revision date of 6/08/2022, which stated that the resident has an ADL self-care performance deficit related to activity intolerance, confusion, fatigue, and CVA with right-sided hemiparesis. The goal had a revision date of 1/19/2026, and it stated that the resident will improve the current level of function in ADLs through the review date, 5/10/2026. Some of the interventions included TRANSFER: The resident requires Mechanical Lift (SIT-TO-STAND) with 2 staff assistance for transfers in/out of bed and 2 person assist for toileting. BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. DRESSING: Allow sufficient time for dressing and undressing. DRESSING: Assist the resident to choose simple comfortable clothing that enhances the resident's ability to dress self.An interview was conducted with Resident #79 on 2/19/26 at approximately 11:24 AM. Resident #79 stated that the night shift Certified Nursing Assistants (CNAs) give her a bed bath, dress her, and help her out of bed and into a wheelchair daily at 5:30 AM. Resident #79 stated that she is aware when she needs to toilet, but getting assistance in a timely manner is the problem. She stated that she must always wait for two CNAs because she is required to transfer using a Hoyer lift. The resident stated that often with her bowels, she has to push greatly to expel them because she has to wait so long for assistance after the urge, and with urination, she frequently urinates in the incontinence brief by the time the staff comes to render her care. The resident stated her goal is to eliminate normally, sitting on the commode, not intentionally in a brief, or lying in bed for a bowel movement. The resident also stated that she is not offered toileting services throughout the day, every 2-3 hours, as she is told by the licensed nursing staff is the expectation. The resident further said she does not receive incontinence care until after lunch daily. The resident reiterated that she does not receive care for her bowels or bladder from 5:30 AM until after lunch daily.The resident adamantly stated that when she activates the nurses' call light, the staff answers it, comes in to hear what care she needs, and then tells her, I have to get someone to help me. The resident said the staff does not return for hours, usually not until after lunch. The resident further stated that when the staff finally provides incontinence care after lunch, the incontinence brief is so heavy that it plops, making a loud noise when they drop it into the trash bag on the floor. Resident #79 stated she is strong enough to use the sit-to-stand lift, but facility staff said she must transfer using the Hoyer lift for her and staff's safety. On 2/19/26 at 11:24 AM, an interview was conducted with the Ombudsman. He stated that he frequently receives calls from Resident #79 regarding her basic care for incontinence, bathing, toileting, and repositioning to maintain her dignity. The Ombudsman stated that the resident is fearful of the Hoyer, and the facility staff stated that it is necessary because many staff have been injured while attempting to transfer the resident without a Hoyer, as she pulls against them. Has psych services on board. An interview was (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conducted with CNA #4 on 2/22/26 at 1:35 PM. CNA #4 stated that she checks on Resident #79 throughout the day but does not provide incontinence care until after lunch, close to 1:00 PM. CNA #4 stated Resident #79 is not toileted because she uses a Hoyer lift for transfers. CNA #4 said she had never seen a special Hoyer pad in the facility, which was designed for toileting and showers.On 2/22/26 at approximately 4:45 PM, a final interview was conducted with the Administrator, DON, and the Regional Nurse Consultant. The above concern was addressed, and an opportunity was offered for the facility's staff to provide information they considered pertinent to the findings. The Administrator stated they had the special Hoyer pad in the facility for Resident #79 to use, and documented interventions they had instituted to allow the resident to use the least-restrictive device for transfers, toileting, and showers, and to allow the resident the dignity she desired during transfers. The facility staff failed to provide any documentation or interventions that they stated were offered to the resident.