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 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. (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 0689 Level of Harm - Actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on information obtained during the Infection Control task, the facility staff lacked documentation of all staff members' COVID-19 information. The findings included: On 2/21/26 at approximately 10:05 AM, the Infection Control information for the facility's staff was requested. The Director of Nursing (DON) stated at 4:38 PM that she was unable to locate COVID-19 information for all staff. There was no documentation that any staff had been provided with education regarding the benefits and potential risks associated with the COVID-19 vaccine, or that staff were offered the COVID-19 vaccine or information on obtaining it.On 2/22/26 at 4:40 PM, a final interview was conducted with the Administrator, DON, and the Regional Nurse Consultant. An opportunity was offered to the facility's staff to present additional information, and the DON stated that they instruct staff to obtain the COVID-19 booster on their own because the facility does not offer it to the staff.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 staff interviews, facility document review, and clinical record review, it was determined that facility staff failed to report an allegation of abuse to the appropriate state agencies for two (2) of 45 residents in the survey sample, Resident #10 and Resident #42. The findings included: 1.The facility staff failed to report an allegation of abuse to the appropriate state agency. 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 completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #10 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 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. 02/19/2026 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 have to lay in her wetness about 1 1/2 weeks ago. I'll call my son and say baby I'm wet. And he will call the nurse's station. Resident #10 also mention that the staff don't know how to talk to you right sometimes, but I talk rough back to them. On 2/21/26 the administrator was asked for any complaints, incidents or grievances involving Resident #10. A review of the Complaint/Grievance Report dated 2/05/26 read that a Certified Nursing Assistant (CNA) told her that She needs to get her ass washed when she refused to take a shower after 10:00 pm. The investigative finding read that the CNA involved in her care said that she didn't tell the resident to get her ass washed, the CNA said when she asked the resident to take her shower, she (resident) started yelling. The plan to resolve the complaint read the staff member was removed from Resident #10, the staff was counseled. The resolution read that staff members were educated and counseled and removed from her assignment. The document also read that the residents were satisfied and the investigation results and resolution steps were reported to the resident. On 2/22/26 an interview was conducted at 12:55 pm, with the Unit Manager, Licensed Practical Nurse (LPN) #2 concerning Resident #10. LPN #2 said according to the resident the CNA came in too late because it was after 10:00 pm because by then she was waiting to take her medication. According to LPN #2 the CNA approached the resident the next night concerning giving her a shower but said the resident started yelling and cursing at her. The LPN was asked if the CNA was assigned to resident the next night. LPN #2 said no, she wasn't assigned to the resident the next night due to the incident. LPN #2 said that she interviewed the staff and consulted Human Resources (HR) concerning what took place. LPN #2 said that HR recommended that the staff be suspended. She said she contacted the Director of Nursing (DON), who informed me to educate the staff. LPN #2 also mentions that the incident occurred on 2/03/26 during the 3-11 shift. LPN #2 said that she should have reassigned the CNA and that she did not conduct any interviews with other staff concerning the incident. On 2/22/26 at approximately 1:15 pm, an interview was conducted with CNA #4. CNA #4 said, The resident was on my assignment on 2/03/26 and had a Bowel Movement (BM), and I told her she was on my list for a shower when she told me to come back after her breathing treatment. I then said, I would have to shower her tomorrow, then she started fussing and cussing at me.On 2/22/26 at approximately 2:15 pm, a brief interview was conducted with Resident #10 concerning the incident with CNA #4. The resident said that she was supposed to get a shower on Tuesday night (night of incident 2/03/26) and the CNA came into her room saying that she would come back after dinner to give her a shower around 10:10 pm. The resident said, I was already given my medicine to help me sleep, and I was slightly sedated. I didn't want to fall or get hurt in the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shower. So, I told her that I wasn't going to take a shower tonight. The CNA told me that I need to get up and wash my ass. I told her that she needed to wash her funky ass after she told me that. It usually takes two aides to shower me, but she was going to try to shower me herself. A review of the interviewer's statements was written on 2/05/26 by seven (7) staff members. All seven (7) staff wrote they didn't witness anything.The Policy: Abuse, Neglect and Exploitation dated 11/01/2020 and revised on 12/01/2022 read: It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Verbal Abuse: Means the use of oral, written or gestured communication or sounds that willfully include disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Reporting/Response: The facility will have written procedures that include Reporting all alleged violations to the administrator, state agency, adult protective services, and to all other required agencies within specific timeframes: a. Immediately, but not later than 2 hours after the allegation is made. The administrator will follow up with government agencies during business hours to confirm the initial report was received.On 2/22/26 at 2:20 pm, a brief interview was conducted with the administrator. The administrator said she didn't report the incident and that she and the DON were away when it occurred. 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. 2. The facility staff failed to ensure an allegation of missing property was reported timely to the administrative staff and state agencies. Resident #42 was originally admitted to the facility 12/16/25. The resident has never been discharged from the facility. The current diagnoses included: Muscle weakness and Type 2 Diabetes. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/23/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #42 cognitive abilities for daily decision making were intact. This indicated that Resident #42's cognitive abilities for daily decision making were moderately impaired. In sectionGG(Functional Abilities Goals), the resident was coded as requiring supervision or touching assistance with toileting, shower/bath self, upper body dressing, and lower body dressing, and coded as requiring set-up or clean-up assistance with eating. On 02/20/2026 at approximately 2:44 pm, during the initial tour, Resident #42 said that she reported to a nurse supervisor and other staff two weeks ago that she was missing two (2) debit cards, a driver's license, and an insurance card. The resident also mentioned that she had contacted her bank.02/20/2026 at approximately 3:49 pm, Licensed Practical Nurse #2, concerning the above allegation, said that she contacted supervisors from all shifts concerning the allegation, saying that none of the supervisors were aware of the allegations. LPN #2 said she spoke with the Social Worker, who is now filing a grievance with the resident regarding her allegation. On 02/20/2026 at approximately 3:58 pm., a brief interview was conducted with the DON and administrator. The administrator said that she has initiated a Facility Reported Incident (FRI). On 2/21/26, an interview was conducted with the Housekeeping (HK) concerning Resident #42. The HK staff said that over a week ago, while she was in the resident's room to pick up her laundry, the resident complained that she was missing her ID cards and her Medicaid card. She was informed to contact her family first, then the administration. The HK staff also mentioned that she told the resident that she couldn't report the incident. The HK stated, I helped her look for them, moved the bed, looked in laundry. I did tell one of the LPNs who works up front. I should have told my boss.The Policy: Abuse, Neglect and Exploitation dated 11/01/2020 and revised on 12/01/2022 read: Policy: It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Misappropriation of Resident Property: means the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent.Reporting/Response: The facility will have written procedures that include Reporting all alleged violations to the administrator, state agency, adult protective services, and to all other required agencies within specific timeframes: a. Immediately, but not later than 2 hours after the allegation is made. The administrator will follow up with government agencies during business hours to confirm the initial report was received.On 2/22/26 at 2:20 pm, a brief interview was conducted with the administrator. The administrator said that the incident should have been reported by staff once they were informed of the incident and a FRI should have been initiated.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.

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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 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 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 (continued on next page)

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Cypress Pointe Rehabilitation and Nursing	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	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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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, clinical record review, and review of facility documents, the facility staff failed to provide services to maintain hearing abilities for 1 of 45 residents (Resident #14), in the survey sample.The findings included: The facility staff failed to ensure that Resident #14 have access to and receive proper treatment and assistive devices to maintain hearing abilities.Resident #14 was no longer a resident of the facility; therefore, a closed record review was conducted. Resident #14 was admitted to the facility on [DATE] after a hospital stay. The resident's diagnoses included Parkinson's disease without dyskinesia, major depressive disorder, and muscle weakness. Resident #14 was coded as rarely/never understood so there was no Brief Interview for Mental Status (BIMS) completed.During an observation tour on 2/19/26 at 1:50 PM it was observed that Resident #14 was not wearing hearing aids. On 2/19/26 at 1:55 PM an interview was conducted with Registered Nurse (RN) #2. RN #2 stated that she cannot find the hearing aids for Resident #14 and she believes they have been lost. On 2/20/26 at 5:25 PM an interview was conducted with the Administrator and Director of Nursing (DON). The Administrator stated that she and the DON did not know that Resident #14 was missing her hearing aids until 2/19/26 when they were informed by the Unit Manager that Resident #14 did not have them. On 2/21/26 at 9:15AM the Administrator stated that she spoke with the Resident #14's daughter the prior night and discussed that the hearing aids were lost and the plan is for the facility to set up an Audiologist appointment. On 2/21/26 at 1:00 PM an interview was conducted with Resident # 14's Daughter. Resident # 14's Daughter stated that in 2018 she purchased Resident #14 a new pair of hearing aids and in 2021 the facility Social Worker informed her that the facility staff lost the hearing aids. Resident # 14's Daughter also stated that in January 2023 she purchased another pair of hearing aids for Resident #14 that cost over $5000.00. Resident # 14's Daughter further stated that in August of 2024 the facility lost the hearing aids again. Resident # 14's Daughter lastly stated that she has spoken with the facilities Director of Social Worker about this many times and was told that the facility is not responsible for her Mother's hearing aids. On 2/21/26 at 2:50 PM an interview was conducted with the Director of Social Services. The Director of Social Services stated that on 8/7/2025 during a care plan meeting, Resident #14's daughter informed the staff that Resident #14's hearing aids are missing. The Director of Social Services also stated that the facility has not assisted the resident or resident representative in locating resources, making appointments, or setting up transportation regarding replacing the lost hearing aids. The Care Plan with a created on date of 12/4/20 read that resident has a communication problem r/t Head Injury, Weak voice, HOH wears hearing aids, decreased visual acuity, increasing confusion. The goal is the resident will be able to make basic needs known on a daily basis through the review date. The intervention for Resident #14 was ensure hearing aid to both ears are in place.The facility's Hearing and Vision policy with a date reviewed/revised of 12/1/2022 reads, Policy: It is the policy of this facility to ensure that residents have access to and receive proper treatment and assistive devices to maintain vision and hearing abilities. Policy Explanation and Compliance Guidelines: 3. The social worker /social service designee is responsible for assisting residents, and their families, in locating and utilizing any available resources(e.g. Medicare or Medicaid program payment, local health organizations offering items and services which are available free to the community), for the provision of the vision and hearing services the resident needs. 4. Once vision or hearing services have been identified, the social worker/social service designee will assist the resident by making appointments and arranging for transportation.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 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 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews and a review of facility documents, the facility staff failed to ensure that the binding arbitration agreement was clearly explained to three (3) of 45 residents (Residents #97, 3, and 79) in the survey sample. The findings included: 1. The facility staff failed to ensure that the binding arbitration agreement was clearly explained to Resident #97. Resident #97 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses included stroke with left hemiplegia, chronic back pain, and diarrhea. The resident had not been admitted to the facility long enough for the Minimum Data Set (MDS) to be completed; therefore, the following information was obtained from the Admission/readmission Screening dated 2/15/26. The screening revealed the resident was alert and oriented to person, place, and situation, and was verbally appropriate.An interview was conducted with Resident #97 on 2/22/26 at approximately 1:37 PM. The focus of the interview was the arbitration agreement, which the resident signed during the admission process. The resident stated he didn't recall signing a document that would deprive him of the right to a trial by a judge or jury in the event of a dispute between him and/or his family and the facility. The resident further stated that he believed the facility staff were good people, so he was not too concerned about possibly needing to activate the litigation process. An interview was conducted with the Admissions Director on 2/22/26 at approximately 3:58 PM. The Admissions Director stated that when reviewing the admission documents, she reads the arbitration agreement to the resident and/or the person completing the admission documents. The Admissions Director did not state that the resident said that he understood what an arbitration agreement was or that the resident was told he had the right to decline the agreement by simply crossing out the document, and a copy was not left with the resident for further review to make an informed decision prior to the allowed 30 days to rescind the agreement. 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 Regional Nurse Consultant stated that the document was legal and binding because the resident signed it. 2. The facility staff failed to explain the binding arbitration agreement to Resident #3 in a manner that the resident understood.Resident #3 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses included Chronic pain in the right foot, Bipolar I disorder, and COPD. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 1/31/26, was coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 15 out of 15. This indicated that Resident #3's cognitive abilities for daily decision-making were intact.An interview was conducted with the resident on 2/22/26 at 9:35 AM. During the interview, the resident stated that she was not knowledgeable of the binding arbitration agreement and how it affected her. This information was conveyed to the Admissions Director and the Director of Social Services. The Director of Social Services stated on 2/22/26 at approximately 2:45 PM that she and the Admissions Director interviewed Resident #3 regarding the binding arbitration agreement. The Director of Social Services further stated that the resident was unfamiliar with the agreement, and it was explained to her in a manner she understood. An interview was conducted with the Admissions Director on 2/22/26 at approximately 3:58 PM. The Admissions Director stated that when reviewing the admission documents, she reads the arbitration agreement to the resident and/or the person completing the admission documents. The current Admissions Director was not the person who witnessed Resident #3's signature on 9/8/2023.There was no documentation that stated that the resident said she understood what an arbitration agreement was or that the resident was told she had the right to decline the agreement by simply crossing out the document, and a copy was not left with the resident for further review to make an (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	informed decision prior to the allowed 30 days to rescind the agreement. 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 Regional Nurse Consultant stated that the document was legal and binding because the resident signed it.3. The facility staff failed to ensure that Resident #79 understood the terms of the binding arbitration agreement. 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.An interview was conducted with the resident on 2/22/26 at 9:55 AM. During the interview, the resident stated that she was unaware of the binding arbitration agreement she had signed three years ago. This information was conveyed to the Admissions Director and the Director of Social Services. The Director of Social Services stated on 2/22/26 at approximately 2:45 PM that she and the Admissions Director interviewed Resident #79 regarding the binding arbitration agreement. The Director of Social Services further stated that the resident was unfamiliar with the agreement, and it was explained to her in a manner she understood. An interview was conducted with the Admissions Director on 2/22/26 at approximately 3:58 PM. The Admissions Director stated that when reviewing the admission documents, she reads the arbitration agreement to the resident and/or the person completing the admission documents. The current Admissions Director was not the person who witnessed Resident #79's signature on 2/1/2023.There was no documentation that stated that the resident said she understood what an arbitration agreement was or that the resident was told she had the right to decline the agreement by simply crossing out the document, and a copy was not left with the resident for further review to make an informed decision prior to the allowed 30 days to rescind the agreement. 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 Regional Nurse Consultant stated that the document was legal and binding because the resident signed it.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, family interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to notify the resident's family representative (daughter) of a change in condition for one (1) of 45 residents (Resident #8), a closed record resident in the survey sample. The findings include: Resident #8 was originally admitted to the facility on [DATE] and readmitted on [DATE] after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included: Hemiplegia and Hemiparesis following Cerebral Infarction affecting the right dominant side and Cognitive Communication Deficit. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 11/29/25, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 2 out of a possible 15. This indicated that Resident #8's cognitive abilities for daily decision making were severely intact. In sectionG(Physical functioning), the resident was coded as requiring partial/moderate assistance with oral hygiene and personal hygiene. Coded as dependent with toileting hygiene, shower/bathe self, and taking on and putting off footwear. Coded as requiring substantial/maximal assistance with upper body dressing and lower body dressing. Requires assistance with eating set-up or clean-up. The personal-centered care plan dated 7/10/25 read that the resident has an ADL self-care performance deficit r/t Activity Intolerance, Fatigue, Impaired balance, and Tremors. The Goal for Resident #8 will be to maintain the current level of function in bed mobility, transfer, eating, and dressing. The intervention included the resident being totally dependent on 2 staff for transferring. On 2/20/26 at approximately 9:05 am, an interview was conducted with an Adult Protective Services worker (APS). The APS worker said they didn't validate these concerns of abuse due to the client being in the hospital and not returned to the facility. One concern in question was that the client had an incident during therapy in which she appeared to overexert herself, so the therapist requested the facility to put her back in bed because she became unresponsive to commands during therapy. After putting her in bed, no one came back to check on her. The nurse had been made aware that she was back in her bed, but it was said that no one had come. The Fire Department came and found the client was in Atrial Fibrillation (afib). The Medication Administration Record (MAR) revealed the resident received Tetrabenazine Oral Tablet 25 MG (Tetrabenazine). Give 1 tablet by mouth three times a day for tremors. Start Date: 11/26/2025 9:00 pm. A review of the February 2026 MAR revealed the resident missed two (2) doses of the above medications that were ordered to help her with her tremors on 2/08/26 and 2/09/26. The Change in Condition (CIC) dated 1/09/26 at 2:22 pm., revealed at the time of evaluation resident vital signs were Blood Pressure: BP 128/83, Pulse: P 103, (Regular), Respiration 16, Temp: T 98.5 Route: Forehead, Pulse Oximetry: O2 93.0 % Room Air and weight 101.2 lb obtained on 1/01/26 using the mechanical lift scale.0 A timeline of events that occurred on 1/09/26 leading up to Resident #8's change in condition, resulting in hospitalization, was as follows:At 8:20 am, the resident is waiting in the lobby for transportation to an appointment.At 9:00 am, the Medical Records staff called the insurance company to report a transport no-show.At 11:30 am, a Certified Occupational Therapy Assistant (COTA) saw the resident sitting in the day room. Awake but felt hot. Resident taken to the dining room. The COTA progress note read, Patient seen for ADL/ROM; however, the patient was sweating, non-verbal, with increased tremors, and the nurse was made aware. Patient dependent on transfer back to bed.At 12:00 pm, Put resident to bed with aide assistance. Resident awake but not talking. COTA, showed Licensed Practical Nurse (LPN) #5 resident's hand and arms are discolored.At 12:58 pm, Physical Therapy session with Physical Therapist (PT) #4, Resident not attempting to initiate tasks in therapy. pt. alert but not verbally responding, unable to complete task.At 1:40 pm, the resident's daughter-in-law signed in as a visitor according to the facility's sign-in sheet.At 2:00 pm, the clinician was notified.At 2:15 pm, the (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	paramedics arrived. The following interviews were conducted:On 2/19/26 at approximately 7:35 pm, an interview was conducted with LPN #5. LPN #5 said, The Certified Nursing Assistant said that the resident's daughter (meant daughter-in-law) wanted the resident's vital signs checked. Her vital signs were due to be checked at 2:00 pm. The resident's daughter (daughter-in-law) started screaming, saying you need to check my mom's vital signs. I called the unit manager and the Director of Nursing (DON). Her heart was tachycardic; otherwise, vital signs were normal. LPN #2 also mentioned that when she went into the resident's room, the resident was talking until her daughter-in-law came back into the room. LPN #2 then said that due to the resident's altered mental status and unresponsiveness, the doctor said to send her to the Emergency Room. LPN #5 further said that the resident was talking and drinking soda and that she was not aware of any incidents occurring in therapy. LPN #5 stated, They took her to the dining room after therapy. She didn't want to stay, so they took her to her bedroom. No one said she was unresponsive in therapy and got overexerted. I would have informed the doctor. Sometimes the therapist may inform you of things. The CNA no longer works here. Most of the time, therapy will push the resident into the dining room. She was a Hoyer Lift (full mechanical lift), and I don't know who the second CNA was. I was put on hold for a brief moment, then I got off the phone with 911. On 2/20/26 at approximately 12:25 pm, an interview was conducted with the COTA staff. The COTA staff said that she had the resident close to lunch time, and she was in the day room. It was hot, and she took off the resident's sweatshirt. She stated that she informed a nurse in the dining room that the resident wasn't verbalizing as much as she usually was, but able to make her needs known, as she has Parkinson's, and mostly spoke very few words. She said the resident was staring more than usual, not making eye contact, and seemed to be daydreaming, unable to focus or answer anything. The COTA said, I requested they put her in bed and helped them put her in bed. The resident was a dependent transfer; she was sitting in her wheelchair. We performed a wheelchair-to-bed transfer; the resident couldn't assist. The resident had Physical therapy earlier that morning. On 2/20/26 at approximately 1:00 pm., an interview was conducted with the Physical Therapist (PT). The PT said that the resident was seen briefly on 1/09/26 early in the morning. PT said, The resident was already in the lobby waiting for transportation to arrive to take her to her doctor's appointment. I asked the CNA to take the resident to the gym to complete paperwork because today was the resident's last day of therapy. After we got to the gym, I asked the resident to stand, but she only looked at me. The resident reached for the parallel bars, and she sat back down. She didn't follow any commands, just stared at me. The COTA had told me that the resident had had episodes like this in the past. On 2/20/26 at approximately 1:50 pm, an interview was conducted with the Medical Records Coordinator (MRC). The MRC said that he had set up an appointment for the resident to attend a doctor's appointment on 1/09/26 at 9:00 am. The MRC said transportation was supposed to pick up the resident at 8:20 am. The insurance company personnel said that the resident's transportation was canceled incorrectly. On 2/21/26 at approximately 5:35 pm, an interview was conducted with LPN #2. LPN #2 said that while in the morning meeting, LPN #5 said that as she entered the resident's room, her daughter was upset, saying her mother doesn't look good and that she's sweating. LPN #5 also said that the DON and LPN #2 were at the bedside giving the resident tea and ice cream. LPN #5 also mentioned that she called the Physician's Assistant, who advised calling 911. LPN #5 said that she was informed that the resident was sweating in the gym. On 2/22/26 at approximately 9:30 am, an interview was conducted with the resident's daughter-in-law. She said that she arrived at the facility around 1:40 pm, entered the resident's room, and found her loved one not at her normal baseline, staring and looking sleepy. The CNA walked in and said she's been like this since noon. They called the paramedics and said she didn't talk to them. Her Blood Pressure was elevated; she was in a fib. The staff informed the paramedics that the resident had been riding the bike in PT and got too hot. We didn't receive a call from the facility before I came in at 1:40 pm. So, from 12 noon to 1:40 pm, no one checked on her. The resident didn't start talking until 1/10/26 after being hospitalized . According to the Weather Forecast for January 9th, 2026, in (continued on next page)

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Cypress Pointe Rehabilitation and Nursing	5580 Daniel Smith Road Virginia Beach, VA 23462

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Virginia Beach, Virginia, the temperature was as follows: morning was 46 , Day was 57 , and evening was 63 . https://world-weather.info/forecast/usa/virginia_beach/january-2026/ 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 said that the temperature was very hot on the day the resident felt hot. The DON said, They adjusted the resident's medications a few days ago due to anxiety. The resident's daughter started yelling, and the resident stopped speaking. She didn't become unresponsive. The resident was admitted to the facility in atrial fibrillation.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and a review of the clinical records, the facility staff failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 45 residents (Resident #96) a closed record resident in the survey sample. Resident #96 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' diagnoses included non-pressured chronic ulcer of other part of left foot. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/28/25 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired for daily decision making. Section M coded resident as having not having a pressure ulcer/injury, scar over a bony prominence.The modified Section M (Skin assessments) coded the resident as having a pressure ulcer/injury, scar over a bony prominence. On 2/21/26 at approximately 12:00 pm, an interview was conducted with the Minimum Data Set Coordinator (MDSC). Involving the above concern. The MDSC agreed that the above assessment had been coded inaccurately and will modify the assessment.On 2/21/26 at approximately 6:35 pm., End of Day meeting was conducted with the DON, the administrator and with the Regional Clinical Nurse Consultant. An opportunity was offered to the facility's staff to provide additional information.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **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 review and revise the person-centered care plan as the resident's condition changed for 1 of 45 residents (Resident #79) in the survey sampleThe 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 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 received a message from the hospital that the resident is no longer allowed to use the sit-to-stand lift. The Administrator stated they had the special Hoyer pad in the facility for Resident #79 to use, and they had 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, and they failed to revise the care plan when they determined the resident was safer using the Hoyer lift.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, family interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to ensure two infected advanced staged wounds on the Left ankle and Left Ischium were treated with antibiotics timely for 1 of 45 residents (Resident #71), in the survey sample. Resident #71 was originally admitted to the facility on [DATE] and readmitted on [DATE] after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included: Pressure ulcer of left heel, Pressure ulcer of left Ischium/buttock unstageable, and Muscle weakness. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 11/29/25, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 2 out of a possible 15. This indicated that Resident #71's cognitive abilities for daily decision making were severely impaired. In section M (Skin Conditions) the resident was coded as being at risk for pressure ulcer/injuries.The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/20/26. In Section M (Skin Conditions), the resident was coded as having 1 unstageable pressure ulcer and 1 unstageable deep tissue injury.a. LEFT BUTTOCK PRESSURE ULCER: The person-centered care plan dated 2/05/26 read that the resident had a pressure ulcer on the left buttock r/t incontinence and decreased mobility. The Goal for the resident: Pressure ulcer will show signs of healing and remain free from infection by/through review date. The interventions were: Monitor/document/report PRN any changes in skin status: appearance, color, wound healing, s/sx of infection, wound size (length X width X depth), stage, and Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. A review of the Treatment Administration Record (TAR) revealed on 2/05/26 at 7:00 am., Santyl Ointment 250 UNIT/GM (Collagenase) Apply to per additional directions topically every day shift for wound care Clean with DWC, pat dry, apply Santyl to Lt. Buttock and cover with clean dressing until healed and on 2/06/26 at 7:00 am., Santyl Ointment 250 UNIT/GM (Collagenase) Apply to left buttock topically every day shift for wound care Apply Santyl topically every dayshift for wound care, Cleanse L buttock with DWC/NS, pat dry, apply Santyl, dry gauze, and cover with foam dressing until healed.Braden Scale Score: 16.0 11/30/25. SENSORY PERCEPTION: Slightly limited. MOISTURE: Rarely Moist. ACTIVITY: Chairfast. MOBILITY: slightly limited. NUTRITION: Adequate. FRICTION & SHEAR: Problem. SCORING 16.A review of the January 2026 Physician's Order Summary (POS) revealed that the resident had orders to receive a Therapeutic Exchange Device (air mattress) q shift for wound care/prevention/to start 1/23/26 at 11:00 pm.A review of the February Physician's Order Summary revealed the following: Doxycycline Hyclate Tablet 100 MG Give 1 tablet by mouth two times a day for infection for 7 Days Verbal Active 02/21/2026.Doxycycline Hyclate Tablet 100 MG Give 1 tablet by mouth two times a day for Wound infection for 7 Days Verbal Active 02/21/2026.Wound timeline-left buttock:10/30/25 -A review of skin assessments revealed redness at the coccyx with treatment in place.A review of Nursing progress notes:02/21/26 at 2:53 pm, read Resident received new order for doxycycline 100 mg x 7 days, Responsible Party (RP) notified, resident also had an order.2/14/26 3:20 am, Resident's buttocks dressing changed w/some drainage noted, foul smell and redness surrounding the pressure/Santyl get applied, covered with foam dressing, re-positioned 2x/pillow supported back. Resident vital signs Temperature 97.7 and 02-97%. Endorse to the next on coming shift nurse. 2/14/2026 at 4:01 pm., Treatment provided to left buttock and heel as ordered. Responsible Party (RP) into visit this shift. Will advise oncoming nurse.2/21/26 at 8:29 pm., nurse received verbal order from hospice nurse and hospice Medical Doctor (MD) for doxycycline 100 mg x 7 days for L buttock wound infection, RP notified by hospice nurse, husband was present during visit, resident also received order PRN for morphine and Lorazepam as needed.On 2/23/26 A review of a wound assessment revealed the first evaluation of a left buttock wound by wound care provider who (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified the wound on 2/23/26 to the left buttock as unstageable covered with 100% Eschar, heavy exudate, seropurulent and malodorous measuring 7.00 cm, Width: 6.00 cm, Depth: 1.00 cm. The treatment consisted of Daily, and as needed (PRN) wound care: Cleanse with 0.125% Dakins solution Calcium Alginate with Silver silicone bordered super absorb. On 2/18/26 at approximately 7:14 pm., during the initial tour, the resident was observed lying in a supine position asleep in her bed.On 2/20/26 at approximately 2:30 pm., a wound observation was conducted of the resident's left buttock with Licensed Practical Nurse (LPN) #1. The wound was malodorous and appeared to be necrotic; no drainage was observed. LPN #1 said the wound remained unchanged. LPN #1 was asked how long the resident's wound has been malodorous. LPN #1 reported that, in the last few wound care visits, the wound had an odor. LPN #1 also said there's no place to document that the resident's wound has an odor.On 02/20/26 at approximately 3:25 pm., a brief interview was conducted with the resident's spouse concerning the resident's wound. The resident's spouse said that he asked the staff if they could keep the resident in bed until lunchtime daily. The resident's spouse also said that the resident will be assigned to hospice services today.2/05/26 New Unstageable- Resident has non-stageable pressure ulcer (L buttocks, 3.5cm x 2cm. New order for treatment- Santyl gel collagenase covered w/ foam dressing. - Dressing done.A review of a hospice note dated 2/22/26 at 9:53 am, read received call that patient has a fever of 101 and requesting re-assessment of left buttock. Temperature 99.4, 94/52, pulse 90. Left buttock wound 7 cm x 7.5 cm wound bed. 100% necrotic peri-wound erythema, warm to touch with foul odor. Treatment: Cleanse with Dakins solution, Santyl to wound bed, covered with dry dressing, and Telfa island dressing. b. LEFT HEEL PRESSURE ULCER: The person-centered care plan revised on 2/19/26 read that resident has a left heel pressure ulcer. The Goal: Pressure ulcer will show signs of healing and remain free from infection by/through review date. The interventions were: Teach resident/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes and assess/record/monitor wound healing weekly Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines.A review of a Physician Assistant's note dated 2/05/26 at 8:00 am read, Resident is seen today at the request of nursing for evaluation of a progression of her left buttock wound. The wound was recently noted to be stage I and is now unstageable. She also has a similar wound on her heel. Nursing has requested that we speak with the family about advance care planning, and a discussion was completed with her husband/RP today. The provider explained hospice-qualifying criteria to him, including her functional decline, recurrent infections, wound progression, and multiple comorbidities. RP agreed that hospice would be a good idea and is willing to meet with hospice representatives.Wound timeline-left heel:12/16/25 at 6:28 am, Resident's (L) heel was observed w/ pressure sore/injury. Bluish discoloration/. Cleaned and dressed w/ gauze covered (applied w/ bacitracin ointment). N/P made aware thru communication log book. Endorse to the next on coming shift Nurse.1/01/26 at 7:21 am, Left Heel, worsened wound per nursing progress note. LPN Charge Nurse notified this writer r/t existing wound to Left Heel possibly worsen. Request placed in MD Book for possible wound consult. Area cleansed with Bacitracin and covered with Dry dressing on this shift. This writer called Emergency Contact, RP, no answer. This writer left detailed voicemail. On Call made aware.1/14/26 Unspecified open wound, left foot, initial encounter- Patient presents with worsening left foot wound with evidence of cellulitis. Referred to wound care for specialized evaluation and management. Ordered x-ray of left foot to assess for underlying bone involvement on 1/2/2026, which showed moderate arthritic changes without acute fracture and no evidence of osteomyelitis. Will continue to monitor wound healing progress.2/4/26 4:10 pm, New treatment to L heel: Betadine to 4x4 gauze and wrap with kerlix daily every day shift for DTI. DO NOT PUT BORDERED DRESSING ON THE WOUND. Unable to complete this shift.2/05/26 Non-pressure chronic ulcer of other part of left foot with fat layer exposed *: Patient continues to have chronic ulcer on left heel with fat layer exposed. X-ray of left foot on 01/02/2026 showed moderate arthritic changes without acute fracture and no evidence of (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	osteomyelitis. Wound care consultation was initiated on 01/02/2026 for specialized assessment and treatment recommendations. Currently applying Santyl ointment for debridement as documented in active medications started 02/04/26. Patient is under comfort care measures per established DNR status with specific directives including no labs and no hospitalizations. Will continue topical wound management and monitor for signs of infection or further deterioration. Zinc supplementation started 01/26/2026 to support wound healing.2/14/26 at 4:01 pm, a review of a nursing progress note read: Treatment provided to left buttock and heel as ordered. Husband is in to visit this shift. Will advise oncoming nurse. A review of a skin and wound date of service note on 2/16/2026 at 3:55 pm., revealed the first evaluation of existing wound by new wound care team. Wound: 1 Location: Left heel, Pressure Ulcer/Injury Stage/Severity: Unstageable Size: 3.9 cm x 6.5 cm x 0 cm. Calculated area is 25.35 sq cm.PROCEDURES: A sharp debridement was not performed today due to this is the first evaluation of the patient and further plan for debridement.On 2/20/26 at approximately 2:30 pm., a wound observation was conducted of the resident's left heel with Licensed Practical Nurse (LPN) #1. The wound was malodorous as LPN #1 removed the resident's dressing that appeared to have a small to moderate amount of drainage present on the resident's pillow, where her left heel was resting, and also had serosanguinous drainage on it. The wound on the left heel appeared to be necrotic/black with a tinge of creamy/yellow tissue on the wound. LPN #1 said the wound remained unchanged. LPN #1 was asked how long the resident's wound has been malodorous. LPN #1 reported that, in the last few wound care visits, the wound had an odor. LPN #1 also said there's no place to document that the resident's wound has an odor. On 02/20/26 at approximately 3:25 pm, a brief interview was conducted with the resident's spouse concerning the resident's wound. The resident's spouse said he asked the staff to keep the resident in bed until lunchtime daily. The resident's spouse also said that the resident will be assigned to hospice services today.According to the nursing progress notes, the hospice nurse assessed only the buttocks, not the left heel, on 2/21/26 at 8:29 pm.A review of nursing progress notes revealed on 2/22/26 at 10:45 am, the hospice nurse performed wound care of the resident's left heel, 90% of eschar with 10% slough wound measure 8 cm x 6cm x 0.2, no warmth, no redness, but odor noted today, dressing done as ordered. A review of the Change in Condition (CIC) note dated 2/22/2026 at 8:17 am, with a concern due to the resident having a fever of 100.1 orally. Nursing observations, evaluation, and recommendations are: The writer assessed the resident and obtained vital signs; the temperature was noted at 100.1. Due to change in condition, writer notified hospice nurse to come to the facility for further assessment. Writer also informed hospice nurse that resident wound requires assessment.Unstageable pressure ulcer-Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. A stable (dry or adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural (biological) cover and should not be removed. https://www.ncbi.nlm.nih.gov/books/NBK2650/table/ch12.t2/.Deep tissue pressure injury remains one of the most serious forms of pressure injury. The pressure is exerted at the muscle-bone interface, but because of the skin's resilience, the color change is not immediate, unlike a bruise. The process leading to deep tissue pressure injury precedes the visible signs of purple or maroon skin by about 48 hours. Then about 24 hours later, the epidermis lifts and reveals a dark wound bed. This phase of deep tissue injury evolution is often confused with skin tears. Within another week, the wound bed is often necrotic. The lag between the pressure event and the change in color of the skin makes the root cause analysis complex. The National Pressure Injury Advisory Panel (NPIAP) has created the photographic timeline shown above to help clinicians more reliability determine the events leading to deep tissue pressure injury. It is important to be aware that 48 hours prior to the patient's skin being deep red, maroon, or purple, he/she may not have been in your facility. https://npiap.com/news/546664/Evolution-of-Deep-Tissue-Pressure-Injury.htmOn 2/20/26 at (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	approximately 5:00 pm, during the end-of-day meeting, the above information was shared with the DON, Administrator, and Regional Nurse Consultant. The DON said that the residents' wounds are progressing even though the nurses are doing the treatments. The DON also mentioned that hospice and the healing agency started working together. The DON also said that the resident was in comfort care prior to the wounds due to her overall health.On 2/21/26 at approximately 5:35 pm, an interview was conducted with License Practical Nurse (LPN) #2. LPN #2 said that the unstageable wound on the resident's left buttock was found on 2/04/26 by a Certified Nursing Assistant (CNA). LPN #2 also said on 1/21/26, the resident had redness on her buttock, which was brought to her attention by a CNA. The LPN stated, I forgot to document it; it was later brought to another staff member's attention. It wasn't mentioned until 2/04/26. LPN #2 also mentioned that the hospice nurse came in today and started the resident on Doxycycline and stated, The Heel wound was found as a DTI initially; it was treated with skin prep and betadine, but deteriorated 2 or 3 weeks afterwards and developed Eschar. Hospice normally doesn't come out on the weekend. The hospice nurse didn't write anything concerning the heel wound.On 2/22/26 at approximately 10:00 am, the facility staff informed the surveyor that the hospice nurse was in Resident #71's room getting ready to perform wound care. The surveyor knocked and was asked to come in by the facility staff. The hospice nurse was getting ready to perform wound care. The surveyor asked the hospice nurse if she could speak to her in the conference room after the wound care was completed. The hospice nurse said I don't feel comfortable talking to a surveyor. The surveyor exited the resident's room and informed the facility staff of what was said by the hospice nurse. The Regional Nurse said that she would immediately contact the hospice nurses' supervisor.On 2/22/26 at approximately 10:35 am, the Hospice Case Manager (HCM) entered the conference room, stating that she had her director on speaker phone. The Director of Hospice (DOH) said that Resident #71 was diagnosed as having Senile Degeneration of the brain. The HCM said that she had gotten a call from the facility yesterday saying they needed someone to assess the resident's left buttock wound because it looked like it was infected. The HCM said the buttock wound was bright red, warm to the touch, got doxycycline, pulled dressing measured 7x6 100% necrotic, foul odor, no drainage. She stated, This morning, I got a call at 8:19 am., They (facility) said she's running a fever of 101. They needed me to re-assess the wound bc they didn't have measurements. Hip still looks the same, redness, odor, mild swelling re-measured 7.5 x 7. Still the same I have only known Kennedy ulcers to be in the sacral area. Low-grade temp 99.4. It is not diagnosed as a [NAME] Ulcer. Not officially on Hospice caseload, officially admitted to hospice-2/11/26-initial nursing assessment. The same treatment- Santyl.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.

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and a review of resident dietary tickets, the facility staff failed to serve portions of the planned menu for two (2) of 45 residents (Resident #32 and Resident #64) in the survey sample. the findings included: 1.The facility staff failed to ensure Resident #32's breakfast included boiled eggs and milk, instead of scrambled eggs and milk. Resident #32 was originally admitted to the facility 4/07/25 after an acute care hospital stay. The current diagnoses included: Hemiplegia and Hemiparesis following Cerebral Infarction Affecting the Left Non-Dominant Side and Contracture of Muscle, Left upper arm. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/17/26 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 8 out of a possible 15. This indicated that Resident #32's cognitive abilities for daily decision making were moderately impaired. In sectionG(Physical functioning), the resident was coded as requiring set up or clean up assistance with eating, dependent with bed mobility, transfers, locomotion, dressing, toileting, oral hygiene, shower/bathe self, personal hygiene, and bathing.On 2/21/26 at approximately 9:05 am, an observation of the resident's tray was conducted at breakfast. The residents' meal tray consisted of scrambled eggs, sausage, an English muffin, coffee, and Orange Juice. The meal ticket read: Hard Boiled Eggs, Sausage Patty, English Muffin, milk, and coffee.On 2/21/26 at approximately 6:35 pm., during the end-of-day meeting, the above concern was shared with the Administrator, DON, and the Regional Nurse Consultant. An opportunity was offered for the facility's staff to provide information they considered pertinent to the findings. On 2/22/26 at approximately 12:25 pm., an interview was conducted with Certified Nurse's Aide (CNA) #1. CNA #1 said that the resident does better with finger foods. On 02/22/2026 at approximately 2:39 pm., an interview was conducted with the Dietary Manager (DM) concerning the residents' breakfast. The DM said that the nursing staff should have communicated their concern to him and he would have prepared the resident a boiled egg and educated the dietary staff as well. 2. The facility staff failed to ensure Resident #64's breakfast included boiled eggs and Bacon. Resident #64 was originally admitted to the facility on [DATE] after an acute care hospital stay. The current diagnoses included: Type 2 Diabetes Mellitus and Morbid Obesity. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/15/26 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated that Resident #64's cognitive abilities for daily decision making were intact. oIn sectionG(Physical functioning), the resident was coded as being independent with eating, toileting, and hygiene, requiring set-up or clean-up assistance with oral hygiene and personal hygiene. Requires supervision or touching assistance with shower/bathe self.On 2/21/26 at approximately 9:00 am., an observation of the resident's tray was conducted at breakfast. The residents' meal tray consisted of scrambled eggs, sausage, an English muffin, oatmeal, apple juice, and hot chocolate.The meal ticket read: Hard Boiled Eggs, Mechanical sausage patty with cream gravy, Bacon x2, English Muffin, Apple Juice, hot chocolate, and Ensure Shake (Vanilla). The resident said this is how the meals come sometimes, but she really wanted bacon and boiled eggs.On 2/21/26 at approximately 6:35 pm., during the end-of-day meeting, the above concern was shared with the Administrator, DON, and the Regional Nurse Consultant. An opportunity was offered for the facility's staff to provide information they considered pertinent to the findings. On 2/22/26 at approximately 12:25 pm., an interview was conducted with Certified Nurse's Aide (CNA) #1. CNA #1 said that, normally, she would contact the kitchen to see if they have what the resident had asked for.On 02/22/2026 at approximately 2:39 pm., an interview was conducted with the Dietary Manager (DM) concerning the residents' breakfast. The DM said that the nursing staff should have communicated their concern to him, and he would have prepared a boiled egg for the resident and educated the dietary staff as well.