STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nans Pointe Rehabilitation and Nursing	200 West Constance Road Suffolk, VA 23434

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations, staff interview, and during the course of a complaint investigation, the facility staff failed to post the most recent survey results in a place readily accessible to residents, family members, and legal representatives of residents. During an observation on 10/21/25 at 11:15 am., a sign was observed in the facility lobby that read: A copy of the most recent Virginia Department of Health inspection report is available upon request.On 10/22/25 during the course of the survey on this day, no posting of survey results were observed, but the above information was listed. On 10/23/25 at approximately 10:30 am., a brief encounter was made by the administrator near the lobby concerning the survey results book. The administrator said that the book was located in a drawer by the receptionist. A pre-exit interview was conducted on 10/23/25 at approximately 1:30 pm., the above findings were shared with the Administrator, The Corporate Consultant and the DON (Director of Nursing) and [NAME] President of Clinical Services. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and clinical record review, the facility staff failed to administer the ordered antibiotic to 1 of 4 residents in the survey sample (Resident #2).The findings included: Resident #2 was initially admitted to the facility on [DATE]. The resident's current diagnoses included an infected diabetic ulcer of the right foot. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 10/17/25, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated that Resident #2's cognitive abilities for daily decision-making were intact. In section GG (Functional Abilities and Goals), the resident was coded as requiring setup or clean-up assistance with eating, partial/moderate assistance with oral hygiene, substantial/maximal assistance with showers/bathes, and upper body dressing, dependent with lower body dressing, personal hygiene, and putting on/taking off footwear. The resident also required substantial/maximal assistance with rolling, lying, sitting, and transfers, and is dependent on toilet transfers and walking. During the tour on 10/21/25 at approximately 12:33 PM, a Contact Precautions sign was observed above the room number where Resident #2 resided. An interview was conducted with the Unit Manager (UM) at 12:05 PM on 10/22/25. The UM stated that the resident's right foot wound presented with increased edema and purulent drainage; therefore, the wound care Nurse Practitioner (NP) obtained a specimen for analysis on 10/15/25.The UM further stated the resident's lab results were sent to the facility on [DATE], and Staphylococcus aureus, Enterococcus faecalis, and Staphylococcus epidermidis were growing in the right foot wound. The assessment based on the wound care NP's progress note, dated 10/20/25 at 12:48 PM, stated that the resident's right foot wound was deteriorating. The note stated that the right foot plantar wound measured 2.1 cm x 1.5 cm x 0.7 cm, had new tunneling 0.9 cm at 6 o'clock, and heavy sanguineous drainage was noted. The right foot had various tissues, including dermis (30%), granulation tissue (60%), and epithelium (10%).The UM stated that on 10/20/25, after the NPs reviewed the lab report and collaborated about the resident's right foot wound, orders were given to start the resident on an intravenous (IV) antibiotic (Linezolid 600 mg BID for 3 days, followed by 300 mg BID as recommended by pharmacist given patient's renal function (Creatinine Clearance, 27), and to obtain a magnetic resonance imaging (MRI) to rule out osteomyelitis. On 10/22/25 at 12:05 PM, during the interview with the UM she stated that the resident had not received any doses of the IV antibiotic. The recount revealed that Linezolid Intravenous Solution 600 MG/300ML (Linezolid) Was Used 600 mg intravenously twice daily for a foot infection for 3 Days. This dose was scheduled to start at 8:00 AM on 10/21/25 and end at 8:00 PM on 10/23/25. The UM confirmed that on 10/21/25 at 8:00 AM, the resident had IV access, and the medication was available for administration. Still, she was unable to state why the medication was not administered. A further review revealed that on 10/21/25, the 8:00 PM dose of Linezolid was not administered because the IV had been dislodged. On 8/22/25 at 8:00 AM, the resident did not receive the antibiotic because the IV access remained dislodged. An IV was inserted on 10/22/25 at 10:32 AM, but the antibiotic was not given. A 10/22/25 nurse's note at 1:00 PM stated the resident was to start the antibiotic that day, but it was not administered. On 10/23/25, a nurse's note at 1:30 PM stated that a consulting physician recommended discontinuing the antibiotic at that time and obtaining blood cultures and labs (ESR, CRP, arterial PVLs).A final interview was conducted on 10/23/25 at approximately 1:30 PM, and the above findings were shared with the Administrator, the Director of Nursing, a Corporate Consultant, and the [NAME] President of Operations. They had no comments and voiced no concerns regarding the above information.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and clinical record review, the facility staff failed to promptly notify the physician and/or practitioner of abnormal lab results for 1 of 4 residents in the survey sample (Resident #2). The findings included: Resident #2 was initially admitted to the facility on [DATE]. The resident's current diagnoses included an infected diabetic ulcer of the right foot. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 10/17/25, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated that Resident #2's cognitive abilities for daily decision-making were intact. In section GG (Functional Abilities and Goals), the resident was coded as requiring setup or clean-up assistance with eating, partial/moderate assistance with oral hygiene, substantial/maximal assistance with showers/bathes, and upper body dressing, dependent with lower body dressing, personal hygiene, and putting on/taking off footwear. The resident also required substantial/maximal assistance with rolling, lying, sitting, and transfers, and is dependent on toilet transfers and walking. During the tour on 10/21/25 at approximately 12:33 PM, a Contact Precautions sign was observed above the room number where Resident #2 resided. An interview was conducted with the Unit Manager (UM) at 12:05 PM on 10/22/25. The UM stated that the resident's right foot wound presented with increased edema and purulent drainage; therefore, the wound care Nurse Practitioner (NP) obtained a specimen for analysis on 10/15/25.The UM stated the resident's lab results were sent to the facility on [DATE], and Staphylococcus aureus, Enterococcus faecalis, and Staphylococcus epidermidis were growing in the right foot wound. The UM further stated that the NP was not notified of the lab results until 10/20/25, for an unknown reason. The UM stated that the lab results are supposed to be viewable on the Point-Click-Care system dashboard, and the results should have been reported to the provider on the day they arrived at the facility. The UM also stated that, as a backup system to prevent missing labs and other pertinent information, the overnight shift is responsible for conducting a 24-hour chart check to identify oversights. Still, the oversight was not recognized until 10/20/25.The UM stated that after the NPs reviewed the lab report, an order was given to start the resident on intravenous (IV) antibiotics and to obtain a magnetic resonance imaging (MRI) to rule out osteomyelitis.A final interview was conducted on 10/23/25 at approximately 1:30 PM, and the above findings were shared with the Administrator, the Director of Nursing, a Corporate Consultant, and the [NAME] President of Operations. They had no comments and voiced no concerns regarding the above information. The facility's policy titled Culture and Sensitivity Lab Results, which was revised on 12/1/2022, stated at number 4b., that the 24-hour shift report may be used by nursing staff, nurse leaders, and the Infection Preventionist to identify residents who have pending lab results . 4d., report positive culture results to the physician/practitioner, including the antibiotics to which the identified pathogen is susceptible.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to provide a specialized therapy evaluation resulting in delayed treatment in services which placed the resident in higher risk for decline for 1 of 4 residents (Resident #3), in the survey sample. Resident #3 was originally admitted to the facility 8/24/25 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Cerebral Infarction Due to Unspecified Occlusion or Stenosis. Hemiplegia and Hemiparesis Following Cerebral Infarction. The admission, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/29/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #3 cognitive abilities for daily decision making were moderately impaired. [NAME] BlvdIn sectionGG(Functional Abilities) the resident was coded as being dependent in oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on, taking off shoes and personal hygiene. Requiring set-up or clean-up assistance with eating. According to the August 2025 Physicians Order Summary dated 8/25/25 (POS). Resident #3 was ordered to receive an Occupational Therapy (OT), Physical Therapy (PT) and Speech Therapy (ST) evaluation.On 10/22/25 at approximately 3:00 pm., an interview was conducted with Other Staff (OS) #6 concerning Resident #3 who did not receive the above therapy services. OS #6 said that Resident's will usually get services upon admission. The staff usually put in therapy orders and if they are skilled, it's assumed they are getting the services. OS #6 also said that It was never brought to my attention that she wasn't getting services. On 10/22/25 at approximately 1:00 pm., an interview was conducted with the Director of Rehab., (DOR). The DOR said that the resident didn't initially have therapy orders. The DOR also said the residents' initial Physical Therapy evaluation (PT), and Occupational Therapy (OT) evaluation wasn't started until 9/19/25 (PT) and 9/22/25 (OT). The DOR also mentioned that his calendar for the month of August lists no therapy start days prior to.On 10/22/25 an interview was conducted at 2:20 p.m., with Licensed Practical Nurse (LPN) #3. LPN #3 said that the resident came in the facility having straight Medicaid. LPN #3 also said that the therapy department screens everyone that's admitted . LPN #3 also mentioned the order dated 8/25/25 was a standing order. Policy: Therapy Evaluation: Dated 11/01/21 and revised on 12/01/22. Reads: The Licensed Therapist will perform initial evaluation upon physician referral and any re-evaluation as appropriate. Policy Explanation and Compliance Guidelines: 1. The rehab department will be notified when a physician order is written for therapy evaluation and treatment. 2. The licensed therapist will perform chart review and initiate the evaluation. 3. The initial evaluation will include, but is not limited to, the following: a. Patient name, date of birth and health insurance ID number. b. Diagnosis. c. Past medical history. d. Prior level of function. e. Current functional level. f. Rehab., potential/severity. g. short- and long-term goals and time frames for completion. h. Treatment Plan of Care to accomplish goals. 4. Initial evaluation will be completed within 2 days from the time the referral is written. 5. Evaluations will be documented, signed by licensed therapist, printed, and placed in chart. 6. Completed evaluation will be signed by the physician.Per the facility's order, the initial evaluation should have been completed in 2 days from the time the referral is written, in this case a verbal active order was given to provide an OT, PT and ST evaluation and treatment.On 10/22/25 at approximately 11:40 am., an interview was conducted with Resident #3 and her spouse concerning rehabilitation (rehab.) services. The spouse said that the resident only had Medicare Part A insurance and not Medicare Part B insurance, therefore the facility Social Worker (SW) told them that nothing could be done with receiving therapy services. The spouse also said that presently, the resident is getting her knee stretched out by therapy to prevent contractures. Some days her legs hurt so bad she couldn't do therapy. Resident #3 lay in her bed nodding in agreement. Resident #3 was asked to rate her knee pain on a pain scale out of 10. Resident #3 said her pain is a 10 but she just received Tylenol for Pain. Resident #3 says she's hurting now. Shortly thereafter, two facility staff were observed entering the resident's room with a Hoyer Lift to get resident up with her wheelchair with a Hoyer lift (11:48 am).On 10/22/25 at approximately 11:45 am., an interview was conducted with the Director of Rehabilitation (DOR). The DOR said that Resident #3 was admitted initially to receive a Physical Therapy (PT) evaluation on 9/19/25 and Occupational Therapy (OT) on 9/22/25. On 10/22/25 at approximately 1:00 pm., the DOR returned saying that he didn't see any notes written in his August 2025 calendar indicating there were PT, OT and ST evaluations.On 10/22/25 1:15 pm., an interview was conducted with the Business

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and clinical record review, the facility staff failed to maintain an infection prevention and control program designed to limit opportunities for infection transmission. The findings included: Resident #2 was initially admitted to the facility on [DATE]. The resident's current diagnoses included an infected diabetic ulcer of the right foot. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 10/17/25, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated that Resident #2's cognitive abilities for daily decision-making were intact. In section GG (Functional Abilities and Goals), the resident was coded as requiring setup or clean-up assistance with eating, partial/moderate assistance with oral hygiene, substantial/maximal assistance with showers/bathes, and upper body dressing, dependent with lower body dressing, personal hygiene, and putting on/taking off footwear. The resident also required substantial/maximal assistance with rolling, lying, sitting, and transfers, and is dependent on toilet transfers and walking. During the tour on 10/21/25 at approximately 12:33 PM, a Contact Precautions sign was observed above the room number where Resident #2 resided. An interview was conducted with the Unit Manager (UM) at 12:05 PM on 10/22/25. The UM stated that the resident's right foot wound presented with increased edema and purulent drainage; therefore, the wound care Nurse Practitioner (NP) obtained a specimen for analysis on 10/15/25. The UM further stated the resident's lab results were sent to the facility on [DATE], and Staphylococcus aureus, Enterococcus faecalis, and Staphylococcus epidermidis were growing in the right foot wound. Resident #2 had a roommate with a PEG tube, but no signage was posted for Enhanced Barrier Precautions (EBP) for this resident. The UM was asked whether the two residents were cohorted in accordance with recommendations from the Centers for Disease Control and Prevention (CDC), and she answered yes. The UM offered no reason for not posting Enhanced Barrier Precautions (EBP) signage for the roommate who had a PEG tube. EBP signage is required in nursing homes to alert staff to wear gowns and gloves when performing high-contact care activities with all residents who are at higher risk of acquiring or spreading an MDRO. These include the following residents: residents known to be infected or colonized with an MDRO; residents with an indwelling medical device, including a central venous catheter, urinary catheter, feeding tube (PEG tube, G-tube), tracheostomy/ventilator regardless of their MDRO status, and residents with a wound, irrespective of their MDRO status. (PowerPoint Presentation). On 10/22/25 at approximately 1:40 PM, the UM stated that she had made a mistake and that, after speaking with the Infection Preventionist (IP) about the two residents' cohorting, the IP stated that they should not remain together. The UM stated that Resident #2 should have been isolated; therefore, they had moved the roommate to another room and placed an EBP sign at his door.A final interview was conducted on 10/23/25 at approximately 1:30 PM, and the above findings were shared with the Administrator, the Director of Nursing, a Corporate Consultant, and the [NAME] President of Operations. They had no comments and voiced no concerns regarding the above information. In an age of increasing antimicrobial resistance, evidence shows that the traditional use of contact precautions in nursing homes is not reasonable for most residents to prevent multidrug-resistant organism (MDRO) transmission. Contact precautions require room restrictions and are generally intended to be time-limited. Citing the inability to restrict residents to their rooms and negatively impacting their quality of life, the Health-care Infection Control Practices Advisory Committee published a white paper, Consideration for the Use of Enhanced Barrier Precautions in Skilled Nursing Facilities.1 Released in June 2021; the report noted that more than 50% of nursing home residents may be colonized with an MDRO. (Updated CMS Recommendations for Infection Prevention in Long-Term Care | Infection Control Today)The facility's Infection Prevention and Control policy, with a revision date of 12/1/2022, stated at number 2 that all staff are responsible for following all policies and procedures related to the program.