

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Nans Pointe Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to ensure a signed bed hold were included in the transfer to the hospital for three of four residents (Resident (R) 44, R12, and R73) reviewed for hospitalization out of 24 sample residents. This failure had the potential of not relaying pertinent medical and demographic information to the receiving hospital. Findings include: 1.) Review of R44's admission Record located in the electronic medical record (EMR) under the Profile tab revealed R44 was initially admitted to the facility on [DATE] with diagnoses including diabetes mellitus. Review of R44's Progress Notes, dated 06/29/26, revealed R44 had been sent to the emergency room after a syncopal episode while in rehabilitation. Review of R44's admission Minimum Data Set (MDS) with an Assessment Reference date (ARD) of 04/12/26, revealed R44 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated R44 had moderate cognitive impairment. Review of R44's discharge MDS located in the EMR under the MDS tab with an ARD of 06/29/26, revealed R44 was discharged to a short-term general hospital with the anticipation of readmission to the facility. Review of R44's EMR revealed there was no documentation of the signed bed hold for the 06/29/26 discharge. 2. Record review of R12's admission Record located under the Profile tab of the EMR revealed an admission date of 03/05/25. R12 had a diagnosis of chronic kidney disease. Record review of R12's quarterly MDS with an ARD of 04/18/26 revealed R12 had a BIMS score of three out of 15 which indicated severe cognitive impairment. During a record review of R12's Progress Notes located under the Progress Notes tab of the EMR, there was no documentation a written notice of transfer was provided to R12 or R12's resident representative and there was no documentation of a signed bed hold when R12 was transferred to the hospital on [DATE]. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of R73's admission Record, located in the EMR under the Profile tab revealed R73 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure, aphasia, dysphasia, acute kidney failure, sepsis, and anemia. Review of R73's admission MDS with an ARD of 02/03/26 revealed a BIMS score of five out of 15 which indicated R73 was severely cognitively impaired. Review of the EMR did not identify a transfer notice or bed hold provided to the resident or responsible party. A review of the progress notes located in the EMR under the Progress Notes tab revealed a nurse's note dated 04/05/26 stating that R73 was sent to the hospital related to a malfunctioning catheter. Another note, dated 04/059/26, revealed R73 was admitted to the hospital related to Acute Kidney Injury (AKI) and Urinary Tract Infection (UTI). During an interview on 07/10/26 at 9:23 AM, the Administrator confirmed there was no signed bed hold for R44's discharge. In a follow up interview at 1:01 PM, the Administrator stated the bed holds are not signed, the forms are just put in the packet that is sent with the resident. He could not find all the transfer summaries. During an interview on 07/10/26 at 2:24 PM, the Admissions Director (AD) stated the bed hold form is placed in the packet that is sent out with the resident. She added she does follow them up with a phone call but does not get them signed. Review of facility policy titled Transfer and Discharge (including AMA), dated 12/01/22, indicated It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except in limited situations when the health and safety of the individual or other residents are endangered. Provide notice of bed hold policy to the resident and representative at the time of transfer, as possible but no later than 24 hours of the transfer.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, record review, interviews, and policy review, the staff failed to wash or sanitize the hands of the residents before a meal and failed to wash or sanitize their own hands while serving the residents their meals for one of four survey days. These failures had the potential to increase the prevalence and spread of foodborne illness and infection for residents served by staff as well as the facility failed to process and store laundry and environmental cleaning items in a safe and sanitary manner to prevent the development and transmission of communicable diseases and infections. Specifically, the facility stored clean resident care and housekeeping items, including bolster pads, used for resident positioning, microfiber cloths, microfiber cleaning pads, dust mops, and clean mop heads, within an area designated for the processing of soiled laundry. This practice created the potential for cross-contamination of clean items through exposure to contaminated laundry and environmental pathogens. This deficient practice had the potential to affect all 118 current residents residing in the facility. Findings include: 1. During a meal observation on 07/08/26 at 11:47 AM the Social Service Assistant and Activities Assistant (AA) were observed to serve meals to the 14 residents sitting in the dining room. The two staff were observed to prepare the meal by opening their drinks, taking lids off of the food setting up the silverware and helping resident adjust their chairs without washing or sanitizing their hands between each resident. The two staff members were observed to bring resident into the dining room and set up their meals without washing their hands. During an interview on 07/08/26 at 12:50 PM the Social Service Assistant stated that he was asked to help at the last minute and just didn't think about washing his hands and probably should have. During an interview on 07/08/26 at 12:55 PM the Activity Assistant (AA) stated that he was pulled into help at the last minute. The AA stated that he had just started working at the facility two weeks ago and did not think to wash his hands. During an interview on 07/09/26 at 11:10 AM the Registered Dietitian (RD) stated that all staff should be washing their hands when assisting resident and help the residents wash or sanitized their hands for the meal. The RD stated that there are new employees, but they should know to wash their hands when assisting the residents. During an interview on 07/09/26 at 11:28 AM the Dietary Manager (DM) stated staff should be washing their hands and the hands of the residents when helping with the meals. The DM stated all staff are expected to wash their hands when assisting resident with anything. A review of the facility's policy titled, 12/01/22, indicated that all staff working in all areas of the facility will perform proper hand hygiene to prevent the spread of infection to residents, staff, and visitors. 2. During observation of the laundry room on 07/09/26 at 12:10 PM, Housekeeping (HSPK) 2 was observed removing and sorting soiled laundry from plastic bags and placing the items into a washing machine. HSKP2 was wearing disposable gloves but no additional personal protective equipment. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the sorting process, soiled laundry was observed repeatedly coming into contact with HSKP2's exposed forearms. Further observation revealed a metal shelving unit located on the soiled side of the laundry room. The shelving unit contained clean items, including bolster pads used for resident positioning, microfiber cloths, microfiber cleaning pads, dust mops, and clean mop heads. The shelving unit was uncovered and not physically separated from the area where soiled linen and clothing were being sorted and processed. As a result, clean items were stored in a location where they could become contaminated through exposure to soiled laundry and airborne particles generated during the sorting process. During an interview on 07/09/26 at 12:10 PM, the [NAME] confirmed the clean mopheads, bolster pads, dust mop, micro cloths, micro cleaning pads should be stored on the clean side in laundry. During an interview on 07/09/26 at 12:20 PM, Housekeeping (HSKP)2 stated, We have gowns, I just didn't put one on, I should have. During an interview on 07/10/26 at 2:10 PM, the Housekeeping Director (HD) stated, She is a new employee, and she should have been wearing personal protective equipment while working with the dirty laundry. Review of the facility policy titled, Soiled Linen and Trash Containers dated 12/01/2022 revealed. Policy: Soiled linen and trash collection receptacles shall not exceed 32 gallons in capacity and shall meet all Life Safety Code requirements (LSC 101, 2012 edition, section 18.7.5.7). Policy Explanation and Compliance Guidelines . 8. Staff shall wear appropriate personal protective equipment when handling soiled linen or trash .		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review, interviews, and review of the facility policy, facility failed to provide incontinence care in a timely manner for one of one resident (Resident (R) 129) reviewed for activities of daily living (ADLs) out of a total sample of 24 residents. This failure to provide timely incontinence care places residents at increased risk of urinary tract infections and skin breakdown. Findings include: Review of R129's admission Record located under the Profile tab of the EMR R129 was admitted to the facility on [DATE] with the diagnosis of osteoarthritis. Review of R129's Progress Notes located under the Progress Notes tab of the EMR and dated 07/06/26 revealed a BIMS score of 15 out of 15 which indicated R129 was cognitively intact. During an interview on 07/10/26 at 9:03 AM, R129 stated she was dependent on staff for toileting and personal hygiene due to urinary incontinence. R129 reported she was typically only changed once per shift despite requiring incontinence care every two hours. She further stated that she was sometimes left in wet incontinence products for several hours. R129 stated, The usual routine is I get changed at 5:00 AM, then I don't get changed again until 10:00 AM or 10:30 AM. Review of R129's Care Plan located under the Care Plan tab of the EMR and dated 07/02/26 revealed R129 required staff assistance for toileting hygiene and was incontinent of bladder. Review of R129's POC Response History Bladder Continence located under the Tasks tab of the EMR for the dates 07/02/26 to 07/10/26 revealed bladder incontinence was documented three times per day. Review of R129's Tasks Progress Notes located under the Tasks tab of the EMR revealed no documentation R129 was checked for incontinence every 2 hours. Review of R129's POC Response History-Toileting Hygiene located under the Tasks tab of the EMR dated 07/02/26 to 07/10/26 documentation indicated R129 was dependent on staff for toileting hygiene. During an observation on 07/10/26 at 9:03 AM R129 was resting in bed working on some beading. R129 reported she had already rung her bell some time ago (i.e., 10 minutes), the silver bell with the red handle. At 9:04 AM, R129 rang the bell. At 9:15 AM there was no response so R129 rang the bell again. During that time, no staff were observed checking on R129 to determine if R129 was wet and needed a brief change. During an interview on 07/10/26 at 9:11 AM, Certified Nurse Assistant (CNA) 2 revealed We are supposed to check the incontinent residents every 2 hours and change the brief if it is wet. During an observation on 07/10/26 at 10:43 AM R129 rang the bell and reported she was incontinent and needed to be changed. R129 reported she had not been changed since 8:00 AM when the therapy staff changed her otherwise I would not have gotten changed as no other staff had checked on her to (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	see if she was wet. At 10:53 AM, R129 rang the bell again as there was no response to when she rang the bell at 10:43 AM. At 11:13, CNA6 entered R129's room and R129 told CNA6 she needed to be changed. CNA6 then donned gloves, went into R129's room, and closed the door to change R129's wet brief, three hours, and 13 minutes after R129 reported the last time the brief was changed. During that time, no staff were observed checking R129 to determine if she was wet and the brief needed to be changed. During an interview on 07/10/26 at 10:48 AM, the Director of Nursing (DON) confirmed that residents who are incontinent of bowel or bladder are to be checked and, if wet or soiled, have their incontinence brief changed every two hours. The DON stated that residents may not be changed if they are dry; however, residents who urinate frequently are care planned to be checked more often. The DON further direct care staff are expected to document each incontinent episode. The DON confirmed CNAs work 8-hour shifts and are expected to document incontinent episodes by the amount, under the Continence Section of the CNA charting module located under the Tasks tab of the EMR. During an interview on 07/10/26 at 3:54 PM, CNA3 reported the CNAs document whether a resident is incontinent or not by shift under the continence tab in the CNA charting tasks. CNA3 stated the CNAs cannot chart number of times incontinent at the end of the shift as they would have to get into the computer each time and document in real time. CNA3 revealed they usually only report to the nurse if someone does not void all shift, not how many times they are incontinent. CNA3 also stated the CNAs do have the ability to chart number of episodes under the CNA Tasks Progress Notes portion of the Tasks but stated it is difficult to get into the computer and chart every incontinent episode every time a resident is incontinent due to time constraints, so they chart incontinence by shift, not by episode. During an interview on 07/10/26 at 3:56 PM, CNA4 stated the CNAs do have the ability to document each incontinent episode in real time or enter a note documenting the total number of incontinent episodes in the CNA Tasks Progress Notes section under the Tasks tab of the EMR. CNA4 reported that many CNAs do not document each incontinent episode or each incontinence check performed. Instead, staff often document only whether a resident was incontinent, rather than the number of times the resident was checked for incontinence or provided with incontinence care. Review of the facility policy Activities of Daily Living dated 12/01/22 indicated. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Nursing staff will record care as it is provided in PCC POC (the EMR) and advise the charge nurse of any issues or concerns . '		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to have adequate equipment to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. Specifically, the call light system did not function in two of 24 resident (Resident (R) 82 and R129) and the facility did not provide residents in these rooms an adequate alternate means to communicate with nursing staff. Findings include: 1. During an interview on 07/08/26 at 12:45 PM R82 stated she had had her call light on since right after breakfast because she had a headache and needed some medication. R82 stated her outside light was not working and she had told staff several times, but no one had fixed it. An observation of the call light panel in her room revealed the light activated. An observation of the light outside the room revealed the light was not on. An observation of the call light panel at the nurse's station was conducted on 07/08/26 at 12:50 PM revealed the call light from R82's was red, blinking with an audible beep coming from the panel. Licensed Practical Nurse (LPN)4 was sitting at the desk with her back to the light panel. She did not respond to the light. Several other staff members walked into the station and out without noticing the light. An observation on 07/08/26 at 1:31 revealed LPN2 sitting in front of the call light panel without noticing the light or the sound of the call light in room [ROOM NUMBER]. LPN 2 was observed to respond to several call lights on the opposite side of the nursing station when an outside light was activated. At 1:34 PM, R82 was observed to come to the nurse's station and ask for her medication. The call light remained on. During an interview on 07/08/26 at 1:41 PM LPN2 was asked if she had noticed the call light which was still alerting on the panel. LPN2 stated she did not notice the call light or hear the beeping coming from the call light panel. During an interview on 07/08/26 at 1:47 PM the Director of Nursing (DON) was alerted to the call light still blinking on the call light panel. The malfunctioning light was pointed out to the DON. The DON stated he had not been notified of any broken or malfunctioning lights and if they had broken lights then a bell would be provided to alert the nurses. The call light was then turned off in the resident's room by staff. The call light had been alerting staff at the nurse's station for 57 minutes before staff went to the resident's room to turn it off. During an interview on 07/08/26 at 1:55 PM the Environmental Service Director (EVD) stated that a fire in room [ROOM NUMBER] had shorted out some of the wiring and they were not sure if it had affected the call lights. 2. Review of R129's admission Record located under the Profile tab of the electronic medical record (EMR) indicated R129 was admitted to the facility on [DATE] with the diagnosis of osteoarthritis. (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R129's Progress Notes located under the Progress Notes tab of the EMR dated 07/06/26 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R129 was cognitively intact. During an observation on 07/07/26 at 11:39 AM, the call light box was absent from where it would normally be located in the wall behind R129's bed. Subsequent interview with R129 at that time confirmed the call light had not worked since she was admitted to the room on 07/02/26 and it had been removed from the wall. R129 revealed she had been given a hand bell to ring. Further observation revealed R129 had a silver hand bell with a red handle sitting on the bedside table. R129 picked up the bell and rang it. After 15 minutes, no one responded to the bell. R129 stated she had to yell to get help and that was not always effective as she was not always heard. R129 revealed she was bedfast and dependent upon staff for Activities of Daily Living (ADLs). Review of R129's Task located under the Task in the EMR dated 07/02/26 through 07/10/26 indicated R129 was dependent in toileting. During an observation on 07/10/26 at 9:03 AM, R129 was resting in bed working on some beading. R129 reported she had already rung her bell some time ago (i.e., 10 minutes), the silver bell with the red handle. R129 said the staff either do not respond or they poke their heads in the door and say they will be right back then they never come back. R129 also revealed she had not been offered a different room with a call light that was functional. During an observation at 9:04 AM, R129 rang the bell. At 9:15 AM, there was no response so R129 rang the bell again. Observation of the nurses' station at that time revealed there were no staff present in area around R129's room or at the nurses' station. At 9:22 AM, an unidentified staff member was observed taking a tray of food into R129's room; 19 minutes after R129 was observed ringing the bell and 29 minutes after she reported she had rung the bell the first time. During that time, no staff were observed checking on R129. During an observation on 07/10/26 at 10:43 AM, R129 rang the bell and reported she was incontinent and needed to be changed. At 10:53 AM, R129 rang the bell again as there was no response to when she rang the bell at 10:43 AM. At 11:02 AM, Housekeeping (HSKP)1, with a clipboard, stopped at R129's door for approximately two seconds but did not go in or talk to R129 before walking down the hall. At 11:04 AM, R129 rang the bell again and the Housekeeping Manager (HM) was going by the door and went in and asked R129 if she needed anything. R129 said she needed to be changed. HM told R129 she would get help then walked down the hall about 75 feet and talked to three staff members. At 11:05 AM, HSKP1 walked back up the hallway. Interview with HSKP1 revealed she was on fire watch and her responsibilities included checking for smoke, fire, and trash that could catch fire. HSKP1 revealed she did not ask the residents if they needed assistance. At 11:06 AM, HM came back and told R129 she had reported to the staff that she needed help then left. At 11:11 AM, R129 rang the bell again. Certified Nurse Aide (CNA)6 was standing right outside the door and did not respond. At 11:13, CNA6 entered R129's room and R129 told her she needed to be changed 30 minutes after R129 had first rang the bell. During an interview on 07/10/26 at 9:11 AM, Certified Nurse Assistant (CNA)2 revealed they were to (continued on next page)		

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