STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	C 10/24/2024

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LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION	179 COMBS STREET SPARTA, NC 28675

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F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted 10/22/2024 through 10/24/2024. The following intake was investigated: NC00223219. 1 of 1 allegations resulted in deficiency. Event ID #9BDV11.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff, Nurse Practitioner (NP), Medical Director (MD) and Poison Control interviews, the facility failed to provide an environment free from a potential hazard when Sodium Polyacrylate (a super-absorbent powder used to absorb large volumes of liquids) and a glass of solidified fruit punch was left at the bedside within a resident's reach for 1 of 3 residents (Resident #1) reviewed for accidents. The findings included: Review of a bottle labeled "Liqui-Loc," generically known as Sodium Polyacrylate, revealed it solidified (made solid) 1500 milliliters of blood and body fluids and contained 1.8 ounces. Resident #1 was admitted to the facility on	F 689	1 - The item was removed from Resident #1 bedside when identified on 10/16/24. Notifications were made to the MD, for medical intervention, as well as a call to Poison Control for further instruction. Resident #1 was monitored for adverse reaction, per the recommendation of Poison Control. Resident #1 had no adverse reaction, and it could not be confirmed whether the resident ingested the substance. 2-On 10/23/24, the leadership team conducted a sweep of the facility to assure there were no chemicals that were not secured appropriately. Items identified were removed immediately. 3 -Education was completed by the Director of Nursing and Unit Manager on 10/23/24 to team members, regarding	10/25/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/07/2024

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F 689	Continued From page 1 12/17/2019 with diagnoses which included mild intellectual disability. Review of a quarterly Minimum Data Set (MDS) dated 7/15/2024 revealed Resident #1 was severely cognitively impaired and exhibited no behaviors during the assessment period. Resident #1 required extensive assistance with bed mobility, was dependent for transfers, and required supervision for eating. A care plan dated 8/31/2024 revealed Resident #1 required assistance for activities of daily living (ADL) care and required extensive assist of 1 person for bed mobility and rolling side to side, assist of 2 people to be pulled up in bed, and was a total assist of 2 for transfers using a mechanical lift. An interview was conducted on 10/23/2024 at 8:18 am with the Dietary Manager. The Dietary Manager stated Resident #1 was ordered a dysphagia mechanical diet, no added salt, and stated he was not on thickened liquids. The Dietary Manager stated Resident #1 had received fruit punch, unthickened, as his beverage for dinner on 10/16/2024. An interview was conducted on 10/22/2024 at 6:08 pm with Nurse Aide (NA) #1. NA #1 stated she had worked dayshift (7:00 am to 7:00 pm) on 10/16/2024 and was assigned Resident #1. NA #1 stated she had gone in Resident #1's room to change him near the end of her shift, at which time she noticed a bottle of an unknown substance. NA #1 stated she had placed the bottle in her pocket to take to the nurse. NA #1 stated after she had changed Resident #1, she noticed there was a cup on his bedside table of	F 689	rounding during the normal course of work, with the expectation of no chemicals unsecured, the protocol to follow in the event a substance is determined to be potentially ingested and the use of the Safety Data Sheet (SDS) binder. Staff members that have not received the education will receive education prior to working the next shift. New hires will receive this education from the Director of Nursing or designee during orientation. 4-Audits will be conducted two times a week for 12 weeks, by the Administrator or designee, to include a sweep of 6 rooms, to assure no chemicals are present at bedside. The Administrator will forward the results of the audits to the QAPI Committee monthly for 3 months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. 5-Completion 10.25.2024	

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fruit punch that was half gone and appeared to be solidified. NA #1 stated she then read the bottle and stated it was used to "clog stuff up." NA #1 stated she immediately took the bottle to the nurse's station and reported what she found to Nurse #1. NA #1 stated that she had not noticed the juice when it was served.

An interview was conducted on 10/22/2024 at 10:43 am with NA #2. NA #2 stated that she worked dayshift (7:00 am to 7:00 pm) on 10/16/2024 and was assigned the 300 hall. NA #2 stated she was not assigned Resident #1 but assisted NA #1 with activity of daily living (ADL) care that day. NA #2 stated she did not recall seeing Sodium Polyacrylate on Resident #1's bedside table. NA #2 stated that near the end of the shift, dinner trays were collected. NA #2 stated NA #1 went to the nurse's station with the bottle of Sodium Polyacrylate she had found in Resident #1's room.

A nursing note dated 10/16/2024 at 6:45 pm authored by Nurse #1 revealed NA #1 had found an opened bottle of Sodium Polyacrylate in Resident #1's room. Resident #1 would not state whether he had ingested the product. Juice that was present on the resident's bedside table was gel-like. Poison Control was notified and stated Resident #1 should be okay and monitored for 1 to 2 hours. The Director of Nursing (DON) and the on-call provider were notified.

An interview was conducted on 10/22/2024 at 3:23 pm with Nurse #1. Nurse #1 stated she worked dayshift (6:30 am to 7:00 pm) on 10/16/2024 and was assigned Resident #1. Nurse #1 stated close to the end of the shift, between 6:00 pm and 6:30 pm, she had been

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approached at the nurse's station by NA #1, as she was giving report to Nurse #2, and was given a bottle that was labeled "Liqui-Loc" (Sodium Polyacrylate). Nurse #1 stated NA #1 told her she had found it in Resident #1's room on his bedside table and there was a glass of fruit punch, that was a little over half full, that appeared to be solid. Nurse #1 stated she observed the bottle of Sodium Polyacrylate was opened and appeared to be "missing some" but was over half full of a powder substance. Nurse #1 stated she had never seen Sodium Polyacrylate in the facility and was unsure what it was. Nurse #1 stated she immediately went to Resident #1's room to assess him at which time she obtained vital signs and performed a visual inspection of his mouth. Nurse #1 stated Resident #1 was generally confused and was unable to tell her if he had ingested any of the substance or not. Nurse #1 stated she called Poison Control and was instructed to monitor Resident #1 for gastrointestinal (GI) symptoms, and she called the DON. Nurse #1 stated Nurse #2 took over from that point.

An interview was conducted on 10/22/2024 at 10:33 am with Poison Control. Poison Control stated Sodium Polyacrylate was used to solidify liquids and came in the form of a superabsorbent polymer (plastic) bead/powder. Poison Control stated the biggest concern regarding possible ingestion would be GI obstruction and staff would need to monitor for signs and symptoms which included constipation, diarrhea, fever, vomiting, and bleeding for several days.

A nursing note dated 10/16/2024 at 10:12 pm authored by Nurse #2 revealed the on-call provider returned Nurse #1's call at 7:50 pm.

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Nurse #2 spoke with the Nurse Practitioner (NP) and was advised to send Resident #1 to the Emergency Department (ED) for evaluation due to possible ingestion of a substance noted by Nurse #1. Nurse #2 called the ED at 7:55 pm and gave report to the ED Nurse who stated, "Do not send him if Poison Control said he was okay." Nurse #2 called the on-call provider and was instructed to call Poison Control back to clarify previous conversation with Nurse #1. Nurse #2 called Poison Control at 8:00 pm and was told to "Monitor resident and if any signs or symptoms of gastrointestinal distress, notify resident's primary care provider (PCP). Continue to encourage fluids and ask resident if nursing could clean out his mouth." Nurse #2 called the on-call provider to make her aware of Poison Control's recommendations.

An interview was conducted on 10/22/2024 at 1:21 pm with Nurse #2. Nurse #2 stated she worked night shift (7:00 pm to 7:00 am) on 10/16/2024 and was assigned Resident #1. Nurse #2 stated she arrived at the facility around 6:20 pm and NA #1 was telling Nurse #1 she had found Sodium Polyacrylate on Resident #1's bedside table. Nurse #2 stated Nurse #1 called Poison Control at that time. Nurse #2 stated she spoke with the Nurse Practitioner (NP) and was instructed to send Resident #1 to the Emergency Department (ED) for further evaluation. Nurse #2 stated she called the ED and spoke with the ED Nurse who instructed her not to send Resident #1 to the ED because they would only monitor the resident as recommended by Poison Control. Nurse #2 stated she called the NP back and was given orders to monitor Resident #1 closely, assess for GI symptoms and obtain vital signs every four hours. Nurse #2 stated Resident #1

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did well throughout the night, had no GI symptoms and his vital signs were within normal ranges.

A physician's order dated 10/16/2024 at 10:29 pm revealed Resident #1 was to be monitored for signs and symptoms which included nausea, vomiting, respiratory concerns, signs/symptoms of obstruction (constipation and/or bloody diarrhea) each shift for one week due to possible ingestion of Sodium Polyacrylate and for vital signs to be obtained every four hours for possible ingestion of Sodium Polyacrylate for 24 days.

An interview was conducted on 10/23/2024 at 9:08 am with the NP. The NP stated she was aware one of the nurses had called the on-call provider. The NP stated Resident #1 had gotten a hold of Sodium Polyacrylate and it was unknown if he had ingested any of it. The NP stated he could have spooned it out, but it solidifies quickly. The NP stated she had seen Resident #1 on 10/17/2024 and assessed Resident #1. The NP stated she assessed his abdomen and there were no abnormal findings. The NP stated she had looked up Sodium Polyacrylate and stated it was "nontoxic and could cause constipation but was not anything lethal that would hurt him."

An interview was conducted on 10/23/2024 at 8:38 am with the Medical Director (MD). The MD stated he was aware a substance had been found in Resident #1's room and there was no evidence that Resident #1 had tried to ingest it. The MD stated he was "not going to speculate about what could have happened if he would have ingested it because he had not."

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An interview was conducted on 10/22/2024 at 1:27 pm with NA #3. NA #3 stated she worked night shift (7:00 pm to 7:00 am) on 10/16/2024 and was assigned Resident #1. NA #3 stated she was told in report that Resident #1 had possibly ingested Sodium Polyacrylate and to keep a close eye on him. NA #3 stated Resident #1 did well throughout the night and had no issues.

An interview and observation were conducted on 10/22/2024 at 4:29 pm with the DON. The DON stated she had received a call from Nurse #1 around 6:25 pm and was told Resident #1 had a bottle of Sodium Polyacrylate on his bedside table that appeared to have been poured into a cup of juice. The DON stated staff were unsure if Resident #1 had ingested any of the substance. The DON stated she instructed Nurse #1 to call Poison Control and notify the on-call provider and Responsible Party (RP). The DON stated she also instructed Nurse #1 to monitor Resident #1. The DON stated she informed the Administrator. The DON stated she received an additional phone call from Nurse #1 between 6:35 pm and 6:40 pm and was told the on-call provider had advised Nurse #1 to send Resident #1 to the ED and when Nurse #1 called to give report to the ED, she was told by the ED Nurse not to send Resident #1 because they would only do what Poison Control had recommended and monitor the resident. The DON stated staff monitored Resident #1 and he did well throughout the night with no issues. The DON stated Resident #1 was seen by the NP on 10/17/2024 and no additional orders or labs were recommended at that time. The DON had a picture on her cellphone of the bottle found in Resident #1's room which read "Liqui-Loc solidifier" and was 1.8 ounces. The DON stated they were never able to determine

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how Sodium Polyacrylate got into the facility and verified the substance found in the cup of liquid was never tested.

An interview was conducted on 10/22/2024 at 3:10 pm with the Regional Consultant. The Regional Consultant stated she received a call from the Director of Nursing (DON) on 10/16/2024 and was told Resident #1 had Sodium Polyacrylate found on his bedside table. The Regional Consultant stated staff was unsure if Resident #1 had ingested any of the substance and she asked if they had called Poison Control. The Regional Consultant stated she instructed the DON to do a full search of the building to see if there was any more Sodium Polyacrylate, and none was found. The Regional Consultant stated she had reviewed previous invoices and Sodium Polyacrylate had never been ordered for the facility. The Regional Consultant stated it was never determined how Sodium Polyacrylate got into the facility.

An observation and interview were conducted on 10/22/2024 at 2:00 pm of Resident #1 in his room. Resident #1 was alert and talkative but was unable to be interviewed or answer any questions, with no obvious signs of distress noted.

An interview was conducted on 10/22/2024 at 11:05 am with the Maintenance Director. The Maintenance Director stated he was not familiar with Sodium Polyacrylate and had not used it in the facility. The Maintenance Director stated that he stored all chemicals and supplies in the maintenance building located behind the facility which was always locked. The Maintenance Director stated only three people had access to

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the maintenance building which included himself, the Administrator, and the Regional Maintenance Director.

An observation was conducted on 10/22/2024 at 11:11 am of the Janitorial Supply Room and the maintenance building with the Maintenance Director. Both areas were locked and there were no bottles or packages of Sodium Polyacrylate found.

An interview was conducted on 10/22/2024 at 2:04 pm with the Supply Clerk. The Supply Clerk stated she had been in her current position since August of 2024. The Supply Clerk stated she had not ordered any Sodium Polyacrylate since she started in her position and was unsure what it was. The Supply Clerk stated there were no invoices for the purchase of Sodium Polyacrylate. The Supply Clerk stated that she thought she had observed Sodium Polyacrylate in the nursing supply room earlier in the day, approximately 8 bottles in a white plastic storage box.

An observation was conducted on 10/22/2024 at 2:10 pm of the nursing supply room with the Supply Clerk. The Supply Clerk went halfway across the room on the right-hand side and stated the box was no longer there. The Supply Clerk stated she was not sure where it had been moved or who would have moved it.