| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>An unannounced revisit, recertification and complaint investigation survey was conducted on 05/19/25 through 05/22/25. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness Event ID #VHXE11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A revisit, recertification and complaint investigation survey were conducted from 05/19/25 through 05/22/25. Event ID #VXHE11. The following intakes were investigated: NC00223966, NC00223878, NC00224462, NC00227491,and NC00223755. 1 of the 16 complaint allegations resulted in a deficiency. | F 000 | | |
| F 636 SS=D | Comprehensive Assessments & Timing<br>CFR(s): 483.20(b)(1)(2)(i)(iii)<br><br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>§483.20(b) Comprehensive Assessments<br>§483.20(b)(1) Resident Assessment Instrument.<br>A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:<br>(i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns. | F 636 | | 6/13/25 |

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

Electronically Signed | 06/14/2025

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 636 | Continued From page 1<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems.<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status.<br>(xii) Skin Conditions.<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).<br>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.<br><br>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.<br>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)<br>(iii)Not less than once every 12 months.<br>This REQUIREMENT is not met as evidenced by: | F 636 | | |

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 636 | Continued From page 2<br>Based on record reviews and staff interviews, the facility failed to complete Care Area Assessments (CAA) comprehensively to address the underlying causes and contributing factors of the triggered areas for 1 of 2 residents reviewed for Activities of Daily Living and Indwelling Urinary Catheters (Resident #82).<br><br>The findings included:<br><br>Resident #82 was admitted to the facility on 10/13/24 with diagnoses that included spastic quadriplegic, cerebral palsy and neurogenic bladder.<br><br>Review of Resident #82's 10/13/24 Minimum Data Set (MDS) assessment dated 10/20/24 revealed the Resident's cognition was moderately impaired and he required substantial to maximal assistance with his activities of daily living. The MDS also indicated Resident #82 had an indwelling urinary catheter.<br><br>Review of Section V (CAA Summary) from the admission MDS dated 10/20/24 revealed the care area for activities of daily living for Resident #82. The MDS Coordinator who completed the assessment did not provide any information in the analysis of findings that described the nature of Resident #82's problem, possible causes, contributing factors, and risk factors for the triggered care area. It was noted on the CAA summary that activities of daily living would be addressed in the care plan due to Resident #82's admission MDS assessment.<br><br>Review of Section V (CAA Summary) from the admission MDS dated 10/20/24 revealed the care area for indwelling urinary catheter for Resident | F 636 | Resident #82 no longer resides in the facility.<br><br>Residents residing in the facility have the potential to be affected by the deficient practice. The Director of Nursing reviewed Section V of the MDS assessments for the last two weeks to ensure that the nature of the problem, possible causes, contributing factors, and risk factors for the triggered care area are addressed.<br><br>Education was provided to the interim MDS nurse by the Director of Nursing on the need to ensure that Care Area Assessments are completed comprehensively to address the underlying causes and contributing factors of the triggered areas. Newly hired MDS nurses will receive the education from the Director of Nursing during orientation.<br><br>The Director of Nursing or designee will audit two residents Care Area assessments a week for 12 weeks to ensure the triggered areas have been completed including nature of the problem, possible causes, contributing factors and risk factors.<br><br>The Director of Nursing or designee will forward the results of the audit 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. | |

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 636 | Continued From page 3 | F 636 | | |

#82. The MDS Coordinator who completed the assessment did not provide any information in the analysis of findings that described the nature of Resident #82's problem, possible causes, contributing factors, and risk factors for the triggered care area. It was noted on the CAA summary that urinary catheter would be addressed in the care plan due to Resident #82's admission MDS assessment.

An interview was conducted with the former Minimum Data Set (MDS) Nurse on 05/21/25 at 8:39 AM. The former MDS Nurse confirmed that she completed the CAA assessments of Activities of Daily Living and Indwelling Urinary Catheter for Resident #82. She explained that she had been completing MDS assessments for over 17 years and the only verbiage she documented on the CAAs was "care plan as indicated ARD (Assessment Reference Date) 10/20/24 with lookback per RAI (Resident Assessment Instrument)" and no one has had a problem with it. The former MDS Nurse stated she understood that the verbiage she used did not provide an appropriate description of the triggered areas.

During an interview with the Director of Nursing (DON) on 05/22/25 at 11:20 AM the DON stated she used to be the MDS Nurse for the facility and explained that the reason for the CAAs was to explain the underlying causes and contributing factors for the Residents' triggered care areas in order to "paint a picture of the Resident" so that an informed decision could be made whether to proceed to the care plan and that was what she expected to be done when completing the resident assessment process.

An interview was conducted with the

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 636 | Continued From page 4<br>Administrator on 05/22/25 at 4:15 PM. The Administrator indicated she expected the MDS process to be completed as it was intended. | F 636 | | |
| F 637 SS=D | Comprehensive Assessment After Signifcant Chg<br>CFR(s): 483.20(b)(2)(ii)<br><br>§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and record reviews, the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment following hospice election for 1 of 1 resident reviewed for hospice (Resident #44).<br><br>The findings included:<br><br>Resident #44 was admitted to the facility on 04/23/2024.<br><br>A medical record review revealed Resident #44 was admitted to hospice on 04/23/2025 with hospice admission diagnoses of dementia and failure to thrive. | F 637 | Resident # 44 still resides in the facility and a significant change in status Minimum Data Set assessment has been completed to indicate hospice on 5/26/25.<br><br>Residents residing in the facility that are admitted to hospice services have the potential to be affected by the deficient practice. The Director of Nursing and Regional Nurse Consultant conducted an audit of the last 30 days to ensure any resident admitted to hospice services had a significant change in status Minimum Data Set assessment completed.<br><br>Education was provided to the MDS nurse by the Director of Nursing regarding | 6/13/25 |

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 637 | Continued From page 5<br>A review of Resident #44's MDS assessments revealed no significant change MDS assessment was completed after the resident was admitted to hospice services.<br><br>A phone interview with the Remote MDS Nurse, who was responsible for the MDS assessments at the facility, at 9:17 AM on 05/22/2025 revealed if a resident went to hospice, then the resident should have a significant change MDS assessment completed. She further stated no significant change MDS assessment had been completed for Resident #44 and according to Resident Assessment Instrument (RAI) manual (a manual utilized completing MDS assessments), Resident #44 should have had a significant change MDS assessment completed after she was admitted to hospice services on 04/23/2025.<br><br>An interview was conducted with the Director of Nursing (DON) on 05/22/2025 at 3:34 PM and she stated a resident being placed on hospice is a significant change and a significant change MDS assessment should have been completed within 14 days.<br><br>At 3:38 PM on 05/22/2025 an interview was conducted with the Interim Administrator, and it was revealed during the interview by the Interim Administrator that a significant change MDS should have been triggered and completed when Resident #44 was admitted to hospice. | F 637 | completing a significant change in status Minimum Data Set assessment for residents that have a new order for hospice services within 14 days of the change. Newly hired MDS nurses will receive the education from the Director of Nursing during orientation.<br><br>The Director of Nursing will audit residents with new hospice orders twice a week for twelve weeks to ensure that ensure that a significant change in status Minimum Data Set assessment has been completed within 14 days.<br><br>The Director of Nursing or designee will forward the results of the audit 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. | |
| F 638 SS=D | Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c)<br><br>§483.20(c) Quarterly Review Assessment<br>A facility must assess a resident using the quarterly review instrument specified by the State | F 638 | | 6/13/25 |

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 638 | Continued From page 6<br>and approved by CMS not less frequently than once every 3 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 14 days of the Assessment Reference Date (ARD, referring to the last day of the observation period) for 1 of 23 residents reviewed for Resident Assessment (Resident #38).<br><br>The findings included:<br><br>Resident #38 was admitted to the facility on 10/03/23.<br><br>Review of Resident #38's electronic medical record revealed the following:<br>-A quarterly Minimum Data Set (MDS) assessment with an ARD of 04/12/25 that was marked as completed on 05/15/25.<br><br>An interview was conducted on 05/21/25 at 8:39 AM with the former MDS Nurse who stated that she was aware that she got behind on completing the MDS assessments in the required timeframes and explained that she was given other duties that took her away from her MDS responsibility. The former MDS Nurse reported when she asked the previous Administrator for some support with the MDS process she was denied.<br><br>During an interview with the Director of Nursing (DON) on 05/22/25 at 11:20 AM the DON explained that the MDS assessments were not her responsibility of management, but she was a former MDS Nurse, and she knew that the quarterly assessments could not be completed | F 638 | Resident # 44 still resides in the facility and a significant change in status Minimum Data Set assessment has been completed to indicate hospice on 5/26/25.<br><br>Residents residing in the facility that are admitted to hospice services have the potential to be affected by the deficient practice. The Director of Nursing and Regional Nurse Consultant conducted an audit of the last 30 days to ensure any resident admitted to hospice services had a significant change in status Minimum Data Set assessment completed.<br><br>Education was provided to the MDS nurse by the Director of Nursing regarding setting ARD within 14 days of a significant change. The MDS completion date must be no later than 14 days from the ARD. Newly hired MDS nurses will receive the education from the Director of Nursing during orientation.<br><br>The Director of Nursing will audit residents with new hospice orders twice a week for twelve weeks to ensure that ensure that a significant change in status Minimum Data Set assessment has been completed within the time limits.<br><br>The Director of Nursing or designee will forward the results of the audit to the QAPI Committee monthly for 3 months. The QAPI Committee will review the audit | |

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 638 | Continued From page 7<br>more than 92 days from the prior assessment, or they were late. The DON stated the facility currently utilized an MDS management company to complete their MDS process.<br><br>An interview was conducted with the Administrator on 05/22/25 at 4:15 PM who explained that her expectation was for the MDS to be completed by the regulatory timeframe. The Administrator stated she had an interview with a potential MDS Nurse on 05/26/25 and hoped to fill the position with an experienced MDS Nurse. | F 638 | 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. | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder | F 690 | | 6/13/25 |

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 690 | Continued From page 8<br>receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff and Nurse Practitioner (NP) interviews, the facility failed to change an indwelling urinary catheter as ordered for 1 of 1 resident reviewed for urinary catheters (Resident #82).<br><br>The findings included:<br><br>Resident #82 was admitted to the facility on 10/13/24 with diagnoses that included neurogenic bladder (a condition where bladder function is disrupted due to nerve damage or malfunction, leading to problems with bladder control and emptying). Resident #82 was discharged to home on 11/19/24.<br><br>Review of Resident #82's discharge summary from the hospital and physician orders dated 10/13/24 indicated to change the (indwelling urinary) catheter on 11/01/24.<br><br>The admission Minimum Data Set (MDS) assessment dated 10/20/24 indicated Resident #82's cognition was moderately impaired and had an indwelling urinary catheter. | F 690 | Resident #82 no longer resides in the facility.<br><br>Residents residing in the facility with an indwelling foley catheter have the potential to be affected by the deficient practice. The Director of Nursing audited residents with indwelling catheters to ensure orders were in place for changing of the catheter.<br><br>Education was provided to nurses regarding putting orders in to the electronic medication administration record as ordered by the physician. Furthermore, nurses were educated to place orders from the hospital discharge summary in the electronic medication administration record so that they will be carried out as ordered. Newly hired nurses will receive the education from the Director of Nursing during orientation.<br><br>The Director of Nursing or designee will audit residents with indwelling foley catheters twice a week for twelve weeks to ensure that foley catheter change | |

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 690 | Continued From page 9<br>Review of Resident #82's admission orders transcribed into the resident's medical record by Nurse #1 included an order to change the indwelling urinary catheter on 11/01/24.<br><br>The care plan dated 11/01/24 revealed Resident #82 had an indwelling urinary catheter related to a neurogenic bladder. The goal to prevent skin breakdown would be prevented by utilizing interventions such as keeping the catheter anchored to prevent trauma, assisting with perineal care as needed and monitoring for skin irritation and redness.<br><br>Review of Resident #82's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for the month of November 2024 revealed there was no order transcribed to the MAR or the TAR to indicate the resident's indwelling urinary catheter had been changed as ordered.<br><br>An interview was conducted with Nurse #1 on 05/20/24 at 2:54 PM. The Nurse reviewed Resident #82's discharge summary and physician orders and confirmed she was the admission Nurse for Resident #82 on 10/13/24. The Nurse stated she did not know why the order for the indwelling urinary catheter change did not show up on the November 2024 MAR or TAR to be changed. Nurse #1 reported the nurses would not know to change Resident #82's indwelling urinary catheter if the order was not on the MAR or TAR to change the catheter.<br><br>During an interview conducted with the Director of Nursing (DON) on 05/20/25 at 3:00 PM, the DON reviewed Resident #82's admission orders and noted the order for the indwelling urinary catheter | F 690 | orders are in place.<br><br>The Director of Nursing or designee will forward the results of the audit 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. | |

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 690 | Continued From page 10<br>change to be done on 11/01/24. The DON looked to see if the order was processed correctly and discovered the order for the catheter change was put in the system, but Nurse #1 did not indicate for the order to be put on the MAR or TAR and therefore the order for the indwelling urinary catheter change did not show up to be done. The DON stated the nurse would not know there was an order for an indwelling urinary catheter change on 11/01/24 and acknowledged the catheter had not been changed for Resident #82 since the resident was admitted on 10/13/24.<br><br>An interview was conducted with the Nurse Practitioner (NP) on 05/21/25 at 10:20 AM. The NP explained that on admission to the facility, Resident #82 had a chronic indwelling urinary catheter related to a neurogenic bladder and although the Resident did not have any complications related to the indwelling urinary catheter while he was at the facility, if there was an order to change the catheter then it was her expectation for the catheter to be changed as ordered.<br><br>During an interview with the Administrator on 05/22/25 at 4:15 PM, the Administrator indicated if there was an order for an indwelling urinary catheter change then she expected it to be changed. | F 690 | | |
| F 761 SS=E | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary | F 761 | | 6/13/25 |

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 761 | Continued From page 11<br>instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews and staff and Consultant Pharmacist interviews, the facility failed to remove loose and unsecure pills of various shapes, sizes and colors, failed to remove expired and unlabeled medications, failed to remove discharged residents' medications from a medication cart and failed to secure medications in locked medication carts. These failures occurred on 4 of 4 medication carts (100 Hall, 200 Hall, 300 Hall and 400 Hall medication carts) and 1 of 1 medication room (the main medication room) reviewed for medication storage.<br><br>The findings included:<br><br>1a. An observation of the 100-hall medication cart | F 761 | Resident residing in the facility have the potential to be affected by the deficient practice. The Director of Nursing and Regional Nurse Consultant removed loose pills, expired and unlabeled medications, and discharged residents medications from the medication carts and medication room. In addition, the medication room and carts were checked for medications requiring refrigeration.<br><br>The Director of Nursing provided education to the nurses and medication aides regarding keeping medication carts and the medication room tidy and free of loose pills, expired and/or unlabeled medications. Furthermore the pharmacy | |

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 761 | Continued From page 12<br>was made on 05/21/25 at 3:30 PM accompanied by Nurse #3. The cart yielded 14 loose pills of various shapes, colors and sizes in the bottom of the drawers.<br><br>An interview conducted with Nurse #3 on 05/21/25 at 3:30 PM. The Nurse explained that it was the responsibility of the nurse on the cart to keep the medication carts clean and orderly.<br><br>b. An observation of the 300-hall medication cart was made on 05/21/25 at 2:04 PM accompanied by Nurse #1. The cart yielded 23 loose pills of various shapes, colors and sizes in the bottom of the drawers.<br><br>An interview was conducted with Nurse #1 on 05/21/25 at 2:04 PM. The Nurse explained that it was the responsibility of the third shift nurses to keep the medication carts clean and orderly, but every nurse should do their part in keeping them clean.<br><br>c. An observation of the 400-hall medication cart was made on 05/21/25 at 3:02 PM accompanied by Nurse #4. The cart yielded 4 loose pills of various shapes, colors and sizes in the bottom of the drawers.<br><br>An interview was conducted with Nurse #4 on 05/21/25 at 3:02 PM. The Nurse explained that it was the responsibility of the third shift nurses to keep the medication carts clean and orderly because they had the most time to do it.<br><br>An interview was conducted with the Director of Nursing (DON) on 05/21/25 at 3:40 PM. The DON explained that it was the nurses' responsibility to keep the medication carts clean and orderly | F 761 | provided forms that show the proper storage for some medications and expiration of medications once opened. The education included securing medication carts when not in use. The nurses and medication aides were re-educated that keeping the medication carts and room tidy and free of loose pills and unlabeled medications is an on-going task and not the sole responsibility of third shift. Education included removing medications for discharged residents from the cart and placing in the medication room for return to the pharmacy. Newly hired nurses and medication aides will receive the education during orientation from the Director of Nursing.<br><br>The Director of Nursing or designee will audit the four medication carts and medication room two times a week for twelve weeks to ensure there are no loose pills, no expired medications, no discharged residents medications and proper storage of medications is in place. In addition, the Director of Nursing or designee will audit four times a week for twelve weeks, including weekends and evening shifts, to ensure staff are locking their medication carts when not is direct supervision.<br><br>The Director of Nursing or designee will forward the results of the audit 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 | |

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 761 | Continued From page 13 | F 761 | | |

which included checking for undated and expired medications. She stated the Unit Manager audited the medication carts once a week, but she was on vacation this week. The DON stated she looked at the medication carts last week.

2. An observation was conducted of the 200-hall medication cart on 05/21/25 at 3:15 PM accompanied by Nurse #3. The cart yielded 5 insulin pens of discharged residents.

An interview was conducted with Nurse #3 on 05/21/25 at 3:15 PM. The Nurse explained that the insulin pens should have been removed from the medication cart and sent back to the pharmacy when the residents were discharged from the facility and not left stored on the medication cart.

An interview was conducted with the Director of Nursing (DON) on 05/21/25 at 3:40 PM. The DON indicated that the insulin pens should have been removed by the Unit Manager who audited the medication carts once a week. The DON stated the insulin pens should have been returned to the pharmacy when the resident was discharged from the facility.

An interview was conducted with the Consultant Pharmacist on 05/22/25 at 12:40 PM. The Consultant Pharmacist explained that when a resident was discharged from the facility their medications should be removed from the medication cart. Therefore, the insulin pens should have been removed from the medication cart and returned to the pharmacy.

3. Review of the facility's pharmacy guide information for: *DuoNeb Inhalation solution

further and/or frequency of monitoring.

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 761 | Continued From page 14 | F 761 | | |

indicated the vial of solution left in an open pouch has an expiration date of 14 days. *Open Lantus insulin pen expires in 28 days. *Unopen Lantus insulin pen refrigerate until used. *Open latanoprost eye drops expiration date 42 days. *Open vials of PPD solution expired in 30 days.

Review of the manufacturer's Guidelines for Lantus Insulin Pens indicated: *Unused Lantus pens should be stored in the refrigerator at 36? to 46?. When stored this way, they will last until their expiration date. If you store them at room temperature (up to 86?), they'll last for up to 28 days.

a. An observation was conducted of the 300-hall medication cart on 05/21/25 at 2:04 PM accompanied by Nurse #1. The cart yielded one open and undated vial of lidocaine (a local anesthetic), an open and undated DuoNeb inhalation solution (nebulizing solution) foil pouch, an open and undated Lantus insulin pen and an unopen Lantus insulin pen with the dispensed date of 04/04/25.

An interview was conducted with Nurse #1 on 05/21/25 at 2:04 PM. The Nurse explained that she did not know how long a vial of open lidocaine could be used but stated she would discard it because it had been a long time since a resident had been on the antibiotic the lidocaine was used with. She stated she did not know how long the DuoNebs could be used after the pouch has been opened but the pouch should have been dated when it was opened. Nurse #1 stated she did not know how long the Lantus insulin pen could be used after it was open, but she did know that the unopen Lantus insulin pen should be refrigerated until it was opened.

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 761 | Continued From page 15<br><br>An interview was conducted with the Director of Nursing (DON) on 05/21/25 at 3:40 PM. The DON explained that it was the nurses' responsibility to keep the medication carts clean and orderly which included checking for undated and expired medications. She stated the Unit Manager audited the medication carts once a week, but she was on vacation this week. The DON stated she looked at the medication carts last week. The DON indicated that the vial of lidocaine should have been discarded when it was used on the resident it was needed for, the DuoNeb pouch should have been dated when opened, the insulin pen should have been dated when it was open, and the unopen insulin pen should have been refrigerated until it was needed for the resident. The DON was unclear as to the expiration dates of these medications.<br><br>An interview was conducted with the Consultant Pharmacist on 05/22/25 at 12:40 PM. The Consultant Pharmacist reported the lidocaine should have been discarded after it was used for the resident and not left in the medication cart. She stated the DuoNebs were good for 14 days after opening and since the DuoNebs were not dated they should be discarded. The Consultant Pharmacist reported the open Lantus insulin pen was good for 28 days and the unopen Lantus insulin pen should have been refrigerated until it was needed for the resident.<br><br>b. An observation was conducted of the 400-hall medication cart on 05/21/25 at 3:02 PM accompanied by Nurse #4. The cart yielded 2 bottles of open latanoprost eye drops with open dates of 03/20/25 and 03/31/25. | F 761 | | |

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 761 | Continued From page 16 | F 761 | | |

An interview was conducted with Nurse #4 on 05/21/25 at 3:02 PM. The Nurse stated she did not know how long the latanoprost eye drops could be open before they should be discarded.

An interview was conducted with the Director of Nursing (DON) on 05/21/25 at 3:40 PM. The DON explained that it was the nurses' responsibility to keep the medication carts clean and orderly which included checking for undated and expired medications. She stated the Unit Manager audited the medication carts once a week. The DON stated she looked at the medication carts last week. The DON was unclear as to how long the open latanoprost eye drops could be open before the expiration date.

An interview was conducted with the Consultant Pharmacist on 05/22/25 at 12:40 PM. The Consultant Pharmacist reported that the latanoprost eye drops should have been discarded 42 days after being opened.

c. An observation was conducted of the main Medication room on 05/21/25 at 2:50 PM accompanied by Nurse #1. The medication room yielded 2 open and undated vials of PPD (purified protein derivative) solution (used for tuberculosis skin tests) in the refrigerator dispensed on 02/24/25.

An interview was conducted with Nurse #4 on 05/21/25 at 2:50 PM. The Nurse explained that she did not know how long the PPD solution could be used after it was open and she did not know how long the 2 vials had been in the refrigerator.

An interview was conducted with the Director of

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 761 | Continued From page 17 | F 761 | | |

Nursing (DON) on 05/21/25 at 3:40 PM. The DON explained that it was the Unit Manager responsibility to audit the Medication room once a week. The DON stated the open PPD solution vials should have been discarded in 30 days after being opened.

An interview was conducted with the Consultant Pharmacist on 05/22/25 at 12:40 PM. The Consultant Pharmacist explained that the opened PPD solution was good for 28 days and it should have been dated when it was open so that it would not be used past the expiration date so therefore, the PPD vials should be discarded.

4. An observation was conducted of the 300-hall medication cart which was left unattended and unlocked (lock button out) parked outside the nursing station in the hallway on 05/21/25 from 4:18 PM to 4:25 PM. The observation yielded 17 staff and 2 residents walking directly in front of the unlocked medication cart.

An interview was conducted with Nurse #1 on 05/21/25 at 4:25 PM. The Nurse explained that she had to look for some missing hearing aids in the medication room and when she could not find them in the medication room, she had to look for them down 100 hall. Nurse #1 stated the medication carts should always be locked when not in use.

An interview was conducted with the Director of Nursing (DON) on 05/22/25 at 11:20 AM. The DON explained that the nurses were educated to lock the medication carts when they were out of sight of the medication carts and Nurse #1 and Nurse #4 should have locked their medication carts before they left the carts unattended.

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 761 | Continued From page 18<br><br>During an interview with the Administrator on 05/22/25 at 4:15 PM the Administrator indicated that she expected the nurses to keep the Medication room and medication carts clean and orderly which included discarding the expired medications, dating open medications and keeping the medication carts locked when they were not in use no matter where the medication carts were parked. | F 761 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, | F 880 | | 6/13/25 |

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 19 | F 880 | | |

but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 20<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, and record reviews, the facility failed to follow their Hand Hygiene and Enhanced Barrier Precautions policies when Nurse #2 did not perform hand hygiene prior to donning second pair of gloves and when she did not perform hand hygiene and don new gloves prior to reinserting a new disposable trach cannula. This deficient practice occurred for 1 of 2 staff members observed for infection control practices (Nurse #2).<br><br>The findings included:<br><br>The Enhanced Barrier Precautions (EBP) policy implemented on 07/2023 and reviewed/revised in 07/2024 revealed the following: an order for enhanced barrier precautions will be obtained for residents with any of the following: wounds (e.g. chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, Peripherally inserted central lines, midline catheters) even if the resident is not known to be infected or colonized with a Multi-Drug Resistant Organism.<br><br>A review of the hand hygiene policy implemented on 07/2023 and reviewed/revised on 07/2024 revealed that all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Also, "hand hygiene" was a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). In addition, hand hygiene was indicated and will be performed under the conditions listed | F 880 | Residents residing in the facility have the potential to be affected by the deficient practice.<br><br>The Director of Nursing and Regional Nurse Consultant educated facility staff on hand hygiene. The education included washing hands with soap and water when visibly soiled and hand sanitizer was acceptable when not visibly soiled. Staff were educated that gloves did replace hand hygiene so hand hygiene was required when gloves are removed. Staff were re-educted on the definition of Enhanced Barrier Precautions (EBP) to include types of residents placed on EBP and proper PPE to be worn during certain care of these residents. The PPE includes gloves, gown and mask. Nurses were educated that changing gloves and washing their hands was necessary between discarding the old trach cannula and reinserting a new one.<br><br>The Director of Nursing or designee will audit three times a week for twelve weeks, including evenings and weekends, to ensure staff are wearing proper PPE during specific care for residents on Enhanced Barrier Precautions. In addition, the Director of Nursing or designee will audit five staff members a week for twelve weeks to ensure proper hand hygiene is taking place. This audit will include weekends and evenings as well as random disciplines. | |

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 21<br>in the attached hand hygiene table. Furthermore, the use of gloves did not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. The hand hygiene table included the following conditions under using either soap and water or alcohol-based hand rub was preferred: after handling contaminated objects, before applying and after removing personal protective equipment (PPE), including gloves, and after handling items potentially contaminated with blood, body fluids, secretions, or excretions.<br><br>At 11:20 AM on 05/22/2025, a review of the sign posted on the resident's door for Enhanced Barrier Precautions revealed that during high-contact care activities, a gown and gloves should be worn by the caregiver.<br><br>On 05/22/2025 at 11:04 AM, Nurse #2 was observed during tracheostomy (trach) care. The door was closed for privacy. Nurse #2 sanitized her hands with ABHR and donned a pair of gloves. She removed the old gauze and trach collar. She went to the bathroom sink for warm water on a washcloth and then placed a disposable drape below the stoma site. Wearing the same gloves and not sanitizing her hands, Nurse #2 soaked two gauze pads with hydrogen peroxide and sterile water and cleaned both sides of the stoma. Nurse #2 took two dry 4 x 4 pads and dried both sides of the stoma. Nurse #2 then doffed her gloves and without washing her hands or using ABHR opened new sterile gloves and donned them. Nurse #2 then removed the trach cap and disposable trach cannula. While wearing the same gloves and not sanitizing hands, she then inserted the new disposable trach cannula | F 880 | The Director of Nursing or designee will forward the results of the audit 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. | |

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION | 179 COMBS STREET SPARTA, NC 28675 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 22 | F 880 | | |

and replaced the cap over the stoma site. Nurse #2 wiped collar and neck with dry washcloth and applied a new trach collar. She placed split gauze underneath the trach for skin protection. Nurse #2 applied a new oxygen mask, and she discarded the trash.

During an interview with Nurse #2 at 11:20 AM on 05/22/2025, she stated that she should have worn a gown and mask during the trach care in observance of enhanced barrier precautions. She stated that she had washed her hands. When told that her hands were washed before donning the first gloves, Nurse #2 replied that she probably should have washed her hands before putting on the second pair of gloves and then mixing hydrogen peroxide and sterile water. Nurse #2 did not state that it was necessary to wash or sanitize her hands and apply new gloves between discarding the old trach cannula and reinserting a new one.

During an interview with Nurse #2 at 12:02 PM on 05/22/2025, when asked why she did not wear a gown and mask for trach care, she replied, "Honestly, I don't know. I would have normally. I was flustered this morning."

On 05/22/2025 at 3:40 PM, an interview with Director of Nursing who is currently serving as the Infection Preventionist, revealed that Enhanced Barrier Precautions and hand washing should be followed instinctively and should be used for trach care.

On 05/22/2025 at 3:42 PM, the Interim Administrator revealed that she expected that staff to adhere to all isolation precautions to maintain infection control.

| 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 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION** | **179 COMBS STREET SPARTA, NC 28675** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|