STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345261	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lotus Village Center for Nursing and Rehabilitation	**179 Combs Street , Sparta, North Carolina, 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
F0000	INITIAL COMMENTS An onsite revisit was conducted from 05/11/26 through 05/15/26. Citation F-684 was corrected as of the survey exit date of 05/15/26. Repeat tag was cited. New tags were also cited as a result of the Recertification and Complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance. Event ID: 1F53E7-H2.	F0000		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F0842		

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 reverse for further 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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F0842 SS = D	Continued from page 1 (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by:	F0842		

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F0842 SS = D	Continued from page 2 Based on record review and staff interviews, the facility failed to maintain a complete and accurate medical record by not documenting a resident's elopement from the facility and not documenting a nurse assessment to check for injuries upon the resident's return for 1 of 3 residents reviewed for complete and accurate medical records (Resident #58). Findings included: Resident #58 was admitted to the facility's locked memory care unit on 11/12/25. A statement written as part of the facility's investigation by the Activity Assistant and dated 01/08/26 revealed in part, at approximately 5:05 PM when leaving the facility, Resident #58 was observed walking down the road and had reached a point in the road between a food pantry and a thrift store. The Activity Assistant pulled her car over, asked Resident #58 what she was doing and Resident #58 asked the Activity Assistant for a ride. Resident #58 got into the car and was taken back to the facility. The Activity Assistant asked Resident #58 to go into the facility with her to figure things out, Resident #58 complied with the request and was assisted back to the memory care unit by the Activity Assistant. A statement written as part of the facility's investigation by Nurse #3 and dated 01/08/26 revealed Resident #58 was observed in bed at 4:30 PM when Nurse #3 was conducting a medication pass. Nurse #3 noted a skin assessment was completed and Resident #58 had no open areas or injuries. Review of Resident #58's electronic medical record revealed the only nurse assessment documented on 01/08/26 was at 10:00 PM following a fall Resident #58 had while in the shower. Review of the January 2026 nursing staff progress notes for Resident #58 revealed no entry related to her elopement from the facility on 01/08/26. During an interview on 05/14/26 at 10:25 PM, Nurse #3 reported she was Resident #58's assigned nurse on 01/08/26 during the hours of 6:30 AM to 6:30 PM. Nurse #3 stated she received a call from the Director of Nursing (DON) at approximately 5:10 PM informing her that the Activity Assistant had found Resident #58 walking down the road and was bringing her back to the facility. Nurse #3 stated	F0842		

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F0842 SS = D	Continued from page 3 immediately upon Resident #53's return to the facility, she completed a head-to-toe assessment of Resident #58 with no injuries identified. She explained for any incident, per facility protocol, nurses were to document an assessment, and a progress note in the resident's electronic medical record. Nurse #3 reviewed Resident #58's electronic record and confirmed there was no assessment or progress note documented by her on 01/08/26. Nurse #3 stated she always made sure to document and thought she had for Resident #58. She could not explain what happened and stated her best guess was that it was an oversight. During an interview on 05/15/26 at 12:29 PM, the DON stated that on 01/08/26 upon Resident #58's return to the facility after her elopement, she instructed Nurse #3 to complete a head-to-toe assessment on Resident #58. She stated Nurse #3 assessed Resident #58 and no injuries were identified. The DON reviewed Resident #58's electronic medical record and verified there was no nurse assessment or progress note documented by Nurse #3 on 01/08/26. The DON stated she would have expected Nurse #3 to have documented the nurse assessment and a progress note related to Resident #58's elopement from the facility. During an interview on 05/15/26 at 2:22 PM, the Administrator stated there should have been a nurse assessment and a progress note documented in the electronic medical record related to Resident #58's elopement from the facility.	F0842		