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
E0000	Initial Comments An unannounced revisit, recertification and complaint investigation survey was conducted on 05/11/26 through 05/15/26. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness Event ID #2317CD-H1.	E0000		06/02/2026
F0000	INITIAL COMMENTS A revisit, recertification and complaint investigation survey were conducted from 05/11/26 through 05/15/26. Event ID #2317CD-H1. The following intakes were investigated: 832438, 2569482, 2598004, 2670189, 2680149, 2775505, 2786108, 2787439, 2795720, 2799063, 2980593, 2984039, 2987229 and 2993361. Four (4) of the forty (40) complaint allegations resulted in deficiencies. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) Tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 01/08/26 and was removed on 01/10/26. An extended survey was conducted.	F0000		06/02/2026
F0689 SS = SQC-J	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:	F0689	"Past Noncompliance - no plan of correction required"	06/02/2026

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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F0689 SS = SQC-J	Continued from page 1 Based on observations, record review, North Caroliana (NC) Department of Transportation (DOT) website, and resident, staff, Physician Assistant and Medical Director interviews, the facility failed to supervise a resident, who had a diagnosis of dementia with other behavioral disturbance and known exit-seeking behaviors, from exiting the facility's locked memory care unit unsupervised and without staff knowledge for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #58). Prior to her admission to the Skilled Nursing Facility (SNF), Resident #58 eloped from the previous SNF where she had resided by climbing out a window. On 01/06/26 Resident #58 was deemed incompetent by a court and appointed a guardian. On 01/08/26, Resident #58 removed the screw from the bottom of the window frame in her room and climbed out the window wearing a sweatshirt, overalls and tennis shoes with no jacket in 50-degree Fahrenheit weather. The distance from the windowsill to the ground was 5 feet 11 inches. Resident #58 walked through the back parking lot and down the hill along a public two-lane residential road with no sidewalks. There was no posted speed limit sign; however, according to the NC DOT website, NC law sets speed limits within town or city limits at 35 miles per hour unless otherwise posted. At approximately 5:05 PM, the Activity Assistant observed Resident #58 walking along a residential road approximately 1,056 feet (0.2 miles) from the facility. Resident #58 was transported back to the facility without incident and with no injuries identified. This noncompliance had a high likelihood of causing serious injury or serious bodily harm. Findings included: A hospital Medical Doctor (MD) progress note dated 11/01/25 read in part, Resident #58 arrived at the Emergency Department (ED) on 10/31/25 from the Skilled Nursing Facility (SNF) and was being seen for a mental health evaluation. The SNF staff reported Resident #58 had been making elopement attempts and no longer wanted to be there. Resident #58 was evaluated by the hospital crisis team who recommended acute, inpatient psychiatric care and involuntary commitment. A hospital MD progress note dated 11/05/25 read in part, the MD "received a report from nursing around 5:00 PM yesterday evening that [Resident #58] was having severe anxiety and reported wanting to jump out a window to hurt herself. Suicide preventions were initiated and she was given Seroquel (antipsychotic) with improvement. Discussed this incident with [Resident #58] today and she said it	F0689		06/02/2026

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F0689 SS = SQC-J	Continued from page 2 was a transient (temporary) time that has not returned." Resident #58 was admitted to the facility's locked memory care unit on 11/12/25 with diagnoses that included dementia-moderate with other behavioral disturbance, primary progressive multiple sclerosis (chronic autoimmune disease of the central nervous system characterized by a gradual, steady worsening of neurological function), diabetes, hypertensive heart disease without heart failure, chronic obstructive pulmonary disease (difficulty breathing), anxiety disorder, and depression. A baseline care plan dated 11/12/25 indicated Resident #58 was an elopement risk with the goal that her safety would be maintained through the review date. Interventions included for staff to reorient and redirect as needed and check placement and function of safety monitoring device every shift. Review of Resident #58's comprehensive care plans initiated on 11/12/25 revealed no care plan that addressed wandering or exit-seeking behaviors. A Safe Smoking Screen assessment dated 11/12/25 revealed Resident #58 currently used tobacco, had no plans to stop smoking and required supervision while smoking. Review of the nursing staff progress notes for November 2025 through January 2026 revealed no entries related to exit-seeking behaviors. In addition, there was no entry related to Resident #58's elopement from the facility. A Physician's Assistant (PA) admission progress note dated 11/14/25 revealed in part, Resident #58 was admitted to the facility on 11/12/25 following a hospitalization. The PA noted Resident #58 was admitted to the hospital from another SNF secondary to confusion and multiple attempts to elope from the previous SNF, including an incident where she climbed out of her window. The PA noted under current medications Resident #58 had an order for Seroquel 25 milligrams (mg) every 24 hours as needed (PRN) for agitation at bedtime and no changes were made to her current medications. The admission Minimum Data Set (MDS) assessment dated 11/18/25 noted Resident #58 had moderate cognitive impairment. She had a height of 5 feet 7 inches, weighed 135 pounds and was independent with walking. She displayed no behaviors or wandering and received antipsychotic, antidepressant and anticonvulsant medications	F0689		06/02/2026

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F0689 SS = SQC-J	Continued from page 3 during the MDS assessment look-back period. A PA progress note dated 11/21/25 revealed in part, Resident #58 was seen for a follow-up visit related to her recent admission and also had a form that needed filled out for her capability to manage benefits. The PA noted Resident #58 had a diagnosis of mild cognitive disorder and he was not sure that she would be able to manage her benefits on her own at the time although she might be able to in the future. A PA progress note dated 12/08/25 revealed in part, nursing staff reported Resident #58 had been more confused and agitated that normal. She had been “hovering” around exits and had increased behaviors. Under the psychiatric review of symptoms, the PA noted Resident #58 had difficulty sleeping, increased confusion, agitation and exit-seeking behavior. The PA noted Resident #58’s recent laboratory tests were unremarkable and he would order a urinalysis with reflux (if the initial urine test showed signs of infection or abnormality, an additional in-depth test is conducted on the same urine sample) to rule out a urinary tract infection as the possible cause of Resident #58’s increased confusion and agitation. A PA progress note dated 12/10/25 revealed in part, nursing staff reported Resident #58 had increased behaviors over the past several days and as needed (PRN) Seroquel had helped with her behaviors; however, Resident #58 had been off the medication for several days with increased behaviors since then. Staff were questioning if the medication could be scheduled. An order was provided for Seroquel 25 milligrams (mg) once a day for anxiety and mood. Review of Resident #58’s December 2025 Medication Administration Record (MAR) revealed a physician’s order dated 12/11/25 for Seroquel 25 mg once a day for anxiety and mood. The order was initialed on the MAR daily by nursing staff as administered per physician order. Review of the State of NC Letters of Appointment Guardian of the Person document revealed Resident #58 was deemed an incompetent person and the County Department of Social Services was appointed as the Guardian of the Person by the Clerk of Superior Court effective 01/06/26. A statement written 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	F0689		06/02/2026

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F0689 SS = SQC-J	Continued from page 4 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. Nurse #3 and Nurse Aide (NA) #1 were both on the memory care unit and had just discovered Resident #58's window open with the screen pushed out. During an interview on 05/12/26 at 5:13 PM, the Activity Assistant recalled on 01/08/26 she had just gotten off work at 5:00 PM when her significant other arrived at the facility to take her home. While driving home, they almost made it to the thrift store when she noticed someone walking down the road that looked like Resident #58 and she had her significant other pull over and stop the car. She recalled it was cold outside and dusk at the time, not quite dark, and Resident #58 was wearing a sweatshirt, overalls, beret (brimless, circular soft cap), and tennis shoes with no jacket or gloves. The Activity Assistant got out of the car and went up to Resident #58. She stated Resident #58 was calm but appeared confused and seemed scared that she was going to be in trouble. The Activity Assistant asked Resident #58 what her plan was because it was cold outside and Resident #58 stated she had just gone out for a walk. She stated Resident #58 asked for a ride, she had Resident #58 get into her car and then took her back to the facility. The Activity Assistant walked with Resident #58 back into the facility and when they got to the memory care unit, Nurse #3 and NA #1 were in Resident #58's room. She recalled Resident #58's window was opened and a section of the screen was bent outward where Resident #58 climbed out of the window. The Activity Assistant stated when she found Resident #58 along the road, she called the DON to inform her of the incident. A statement written by NA #1 and dated 01/08/26 revealed in part, NA #1 observed Resident #58 in her room around 4:45 PM to 4:50 PM while completing the last round before dinner. During an interview on 05/12/26 at 5:23 PM, NA #1 confirmed she was working on the memory care unit (MCU) on 01/08/26 during the hours of 6:30 AM to 6:30 PM when Resident #58 eloped from the facility. NA #1 stated for most of the shift, Resident #58 had pretty much kept to herself in her room and she had	F0689		06/02/2026

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F0689 SS = SQC-J	Continued from page 5 been fine when NA #1 had checked in on her every 15 minutes. Around 4:40 PM or 4:45 PM, she and Nurse #3 walked down the unit making rounds and Resident #58 was observed in her room, calm and not displaying any exit seeking behaviors. NA #1 could not recall what Resident #58 was wearing but stated she usually wore a sweatshirt or light weight jacket all the time. NA #1 stated after rounds were completed, she then started getting all the residents to the dining room for dinner. She could not recall the exact time but thought it may have been around 4:50 PM when Nurse #3 received a call from the Activity Assistant stating Resident #58 was found outside the facility. NA #1 stated she and Nurse #3 went to Resident #58's room, Resident #58 was gone and the window was partially opened with the screen bent outward just enough for her to climb out of the window. She recalled it was starting to get dark outside and the weather was cold. NA #1 was not sure of the exact location along the road where Resident #58 was found but stated she could not believe Resident #58 had gotten out of the facility in "the blink of an eye" and down the road so quickly. NA #1 reported when Resident #58 was brought back to the unit, she was calm and had no injuries. She asked Resident #58 where she was going when she left the facility and Resident #58 told her she needed a cigarette and was going to find one. A statement written 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. During an interview on 05/14/26 at 10:25 AM, Nurse #3 recalled she was doing her evening medication pass on 01/08/26 when she entered Resident #58's room at approximately 4:30 PM to administer her medications. Nurse #3 stated after Resident #58 took her medications, she left the room and continued down the hall. When she had completed the remainder of the medication pass, Nurse #3 stated she took the medication cart to the nurses' station and then started assisting the NAs with passing out dinner trays. Nurse #3 reported she grabbed Resident #58's meal tray from the cart and as she reached the door of Resident #58's room, she received a call from the Director of Nursing (DON) asking her if they were missing anyone. Nurse #3 stated she told the DON no one was missing, the DON asked her to go check Resident #58's room and Nurse #3 informed the DON she was at Resident #58's door about to open it to deliver Resident #58's dinner tray. Nurse #3 stated when she opened	F0689		06/02/2026

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F0689 SS = SQC-J	Continued from page 6 the door of Resident #58's room while still on the phone with the DON, Resident #58 was gone and the window was partially open. The DON then told her that the Activity Assistant had found Resident #58 walking down the road and was bringing her back to the facility. She indicated it was approximately 5:10 PM when she received the call from the DON. Nurse #3 stated when she walked into the room to look at the window, Resident #58 had removed the screw from the window frame, and the window was opened about a foot with the screen bent outward. When she looked out the window, Nurse #3 stated she saw footprints in the dirt and assumed they were Resident #58's. Nurse #3 stated Resident #58 could not have been gone for very long because when she asked NA #1 and NA #2 what time they had last seen Resident #58 on the unit, they both stated it was around 4:50 PM when they did rounds. Nurse #3 reported that as soon as Resident #58 was brought back to the unit, she did a head-to-toe assessment of Resident #58 with no injuries identified and Resident #58 was placed on one-to-one staff supervision. She verified she checked and all other residents on the unit were accounted for. Nurse #3 stated when she asked Resident #58 where it was she thought she was going to go, Resident #58 told her that she wanted some cigarettes and "just wanted out of here." Nurse #3 stated that prior to 01/08/26, Resident #58 would pace back and forth on the unit at times but she had never attempted to elope nor had she made any attempts since. A statement written by NA #2 and dated 1/08/26 revealed in part, NA #2 and NA #1 went into Resident #58's room at approximately 4:45 PM to 4:50 PM to check on her and she was lying in the bed. NA #2 was unavailable for an interview at the time of this investigation. A Medical Director progress note dated 01/29/26 revealed in part, Resident #58 had a diagnosis of mild cognitive impairment of uncertain or unknown etiology and resided on the locked memory care unit. The Medical Director noted Resident #58 recently tried to elope but was found unharmed and brought back to the memory care unit. Following the incident, all safety measures were implemented to ensure the unit was locked and secure. Resident #58 had no further elopement attempts but was high risk and required continued care on the locked memory care unit. During an interview on 05/14/26 at 10:59 AM, the	F0689		06/02/2026

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F0689 SS = SQC-J	Continued from page 7 Medical Director verified that she was made aware of Resident #58's elopement on 01/08/26 and from what she recalled, Resident #58 was found outside the facility and brought back unharmed. She stated that Resident #58 obviously had a plan to go somewhere that day but then couldn't remember where it was she was wanting to go. The Medical Director explained that while Resident #58 was physically high-functioning, she had cognitive impairment and would not be safe outside unsupervised which was why she resided on the locked memory care unit. During an observation and interview on 05/13/26 at 8:48 AM, Resident #58 was lying on top of the bed with a staff member sitting in the recliner next to her providing one-to-one supervision. Resident #58 could not recall the date but did remember climbing out the window of her room stating she had "just felt like going for a walk." When asked which way she went once outside, Resident #58 stated she walked down the road "a bit" while looking out the window and pointing to the left side (where the road led toward the funeral home next to the facility) but could not recall how far she walked. She stated the "Activity Girl and her husband" came by and gave her a ride back to the facility. Resident #58 expressed she didn't give them any trouble and stated, "reckon I wasn't supposed to be out there." Resident #58 restated she was just going for a walk but made a bad decision and would have to "deal with the consequences." When asked if she removed the screw from the window frame in order to open the window, she would not provide a direct response and just stated that the screw was in there tight but if someone wanted to, they could get the screw out. During an interview on 05/13/26 at 2:04 PM, the PA recalled he was made aware of Resident #58's elopement but was not sure if someone told him about the incident or if it was documented in the provider communication book. When asked his medical opinion regarding Resident #58 being safe outside the facility unsupervised, he stated that was hard to answer as she was rather high-functioning but she did have some cognitive impairment and might have difficulty trying to find her way back to the facility. The PA stated he felt Resident #58 would likely be safe for a short period of time, but she would not be safe outside unsupervised for a long period of time. During an interview on 05/15/26 at 12:29 PM, the DON recalled that on 01/08/26 she received a call from the Activity Assistant at 5:05 PM informing her that she had picked Resident #58 up along the side	F0689		06/02/2026

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F0689 SS = SQC-J	Continued from page 8 of the road near the thrift store. The DON stated the Activity Assistant reported she was driving home and saw Resident #58 walking down the road and when she asked Resident #58 where she was going, Resident #58 stated she just wanted some fresh air. She stated the Activity Assistant asked Resident #58 if she would get into the car, which she did without resistance, and the Activity Assistant brought her back to the facility. After she spoke to the Activity Assistant, the DON called Nurse #3 and asked if she was missing anyone on the unit. She had Nurse #3 go check Resident #58's room, Nurse #3 reported the door was closed and when she opened the door to the room, the window was open and Resident #58 was gone. The DON stated she was informed that Resident #58 had removed the screw from the window frame, opened the window and bent the screen enough to climb out the window. The DON headed back to the facility and by the time she arrived, the previous Maintenance Director had already fixed the window. When she spoke to Resident #58 about the incident, Resident #58 told the DON that she climbed out the window to get some fresh air. She stated that when Resident #58 returned to the facility, she was assessed by Nurse #3 with no injuries identified and placed on one-to-one staff supervision. The DON verified the facility was aware of Resident #58's elopement attempts from her previous SNF when she was admitted on 11/12/25 but she had not made any elopement attempts while at the facility prior to 01/08/26. The Maintenance Director at the time of this incident was no longer employed and unable to be interviewed at the time of this investigation. The Administrator at the time of this incident was no longer employed and unable to be interviewed at the time of this investigation. Observations of the window inside Resident #58's room were conducted on 05/12/26 at 4:50 PM and 05/14/26 at 4:52 PM. The back parking lot of the facility could be viewed from the window. There was one screw placed in the top and one screw placed in bottom of the window frame preventing the window from opening more than approximately 3 inches. An observation of the window outside of Resident #58's room was conducted with the Maintenance Director on 05/13/26 at 2:38 PM. The ground directly below and leading to the paved parking lot was grass covered. The Maintenance Director used a tape measure and the distance from the windowsill to the ground was 71 inches (5 feet 11 inches).	F0689		06/02/2026

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F0689 SS = SQC-J	Continued from page 9 An observation of the area where Resident #58 was found on 01/08/26 was conducted on 05/12/26 at 5:50 PM. A steep, grass-covered embankment extended along the right side of the facility from the rear to the front, leading down to the parking lot of a funeral home. The facility's rear parking lot connected to a driveway that exited onto a two-lane road without sidewalks. This road went around the funeral home parking lot and downhill to a stop sign. Directly across from the stop sign was a residential property with sloped terrain and trees lining the rear boundary of the property. Turning left at the stop sign, the two-lane road continued approximately 288 feet to a second stop sign (Google Earth was used to calculate the distance between the two stop signs). From the second stop sign, the road led straight ahead into the facility's front parking lot; to the left was an embankment; and to the right was a public two-lane road where a thrift store and food bank were located. The driving distance from the facility's rear parking lot to the area between the thrift store and food bank, where Resident #58 was found, was approximately 0.2 miles (1,056 feet). An online website named Weather Underground was used to obtain the outside weather conditions in Sparta, North Carolina on 01/08/26 which revealed at 4:55 PM: cloudy conditions, temperature of 50 degrees Fahrenheit (F) with no precipitation and South-Southeast wind speed of 8 miles per hour. The Administrator was notified of Immediate Jeopardy on 05/13/26 at 5:00 PM. The facility provided the following Corrective Action Plan of Immediate Jeopardy removal: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 01/08/2026 at approximately 5:05 pm the Activities Assistant was driving home from the building when she saw Resident #58 walking down the side of the road in front of the facility close to a thrift store. The Activities Assistant stopped and asked Resident #58 what she was doing. Resident #58 asked the Activities Assistant for a ride. The Activities Assistant helped Resident #58 into the car and brought her back to the facility and returned her to the 400 hall. The Administrator and Director of Nursing were notified immediately. Resident #58 had removed the screw from the window and was able to open the window enough to get out. The screen was	F0689		06/02/2026

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**

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F0689 SS = SQC-J	Continued from page 10 also bent and pushed outward. When Resident # 58 was asked where she was trying to go Resident #58 stated she was just going for a walk for some fresh air. Resident #58 was unable to tell us how she removed the screw. Nurse #3 assessed Resident #58 for injuries. No injuries were identified. Resident was placed on 1:1 supervision by facility staff and will remain on 1:1 supervision while residing in the facility. The Medical Director and guardian were notified of the event by the Director of Nursing on 01/08/2026. It was determined Resident #58 went out through the window due to the window being open and the screen being bent and pushed out. Resident #58 was being seen by the mental health provider prior to the incident and continues to be seen. Resident #58 was seen by the mental health provider on 01/06/2026 and there were no new orders. Resident #58's care plan was reviewed and updated by the Director of Nursing and interdisciplinary team on 01/09/2026. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Residents currently residing in the facility have the potential to be affected. On 01/08/2026 through 01/09/2026 the Director of Nursing assessed current residents for his/her ability to walk, his/her cognitive impairments, and his/her ability to reasonably remove a windowpane and climb through the window opening. This was assessed by observing the amount of assistance needed during activities of daily living care. No residents were identified at risk during the assessment. During the investigation, a review of residents who pose as a potential elopement risk based on exit seeking behaviors and their ability to exit were assessed using the elopement risk assessment on 01/08/2026 by the Director of Nursing with no additional residents identified. There are currently three residents at risk. All residents have open utilization data assessment (UDA) named "elopement assessments" scheduled for their Admission/ Quarterly, these assessments are completed by floor nursing and are maintained in the residents' medical record. The Maintenance Director conducted a house audit of windows to ensure that windows could not be opened greater than 3 inches (decrease from 6 inches) on 01/08/2026. Any window that had the ability to exceed the 3-inch limit was addressed and additional hardware such as additional screws were put into place. Per fire safety code and adequate alternative safety measures such as fully sprinklered	F0689		06/02/2026

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F0689 SS = SQC-J	Continued from page 11 building, alternative exits, and a fully fire monitored building the windows opening to 3 inches will meet National Fire Protection Agency 101 life safety code. Windows in the facility were audited and new screws added to the tops of the windows. Windows in the facility open right to left. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: An additional screw was added to the top of the window and the screw to the bottom of the window was replaced to allow the window to open 3 inches, previously 6 inches on 01/08/2026 by the Maintenance Director. A review was completed of the Elopement and Wandering Policy by the Administrator and Director of Nursing on 01/08/2026. No changes were needed. The education on the center's Elopement and Wandering Policy was initiated on 01/08/2026 by the Administrator and Director of Nursing. All staff in Nursing (nurses, nurse aides, medication aides), Agency staff, Therapy, Housekeeping, Administration, and Dietary have received education verbally or in-person prior to working. Education was provided face to face for individuals who were on shift, others not on-site were provided with education via phone. The education included ensuring residents that exhibit exit seeking behaviors and/or at risk for elopement receive adequate supervision to prevent accidents in the facility's control. Staff were educated on how to identify exit seeking behaviors, monitor the affected residents, and interventions. Education highlighted that alarms do not replace the necessary supervision of residents. Nor does it negate how vigilant that the staff should be in responding to alarms or actions of the residents that would indicate an elopement risk. Staff were instructed that if they were to witness a resident attempting to open a door or window, he/she should make efforts to remove the resident from the area through redirection and should never stop monitoring the resident. The Administrator and/or Director of Nursing should be notified immediately. Staff were reminded that a binder containing residents that are at risk for elopement are kept at both nurses' stations. The binders are maintained and kept current by the Director of Nursing and/or Social Worker. The Director of Nursing and Social Worker were notified of this responsibility by the Administrator on 01/09/26. When a resident is	F0689		06/02/2026

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F0689 SS = SQC-J	Continued from page 12 identified as high risk for elopement their name and information is added to the binders. Education will be oversighted by DON, anyone not educated on 01/08/2026 will need to be educated in-person prior to their next scheduled shift by the Director of Nursing. On 01/08/2026 the Administrator and Director of Nursing educated all Nurses either in person or via phone that a new elopement risk assessment was to be completed upon admission, quarterly, and with any significant change. The assessments are maintained in the resident's electronic medical record. Newly hired staff members will receive this education in orientation from the Director of Nursing and/or Maintenance Director on the day of orientation. In addition, newly hired nurses are educated on how to identify behaviors that trigger the need for a new elopement risk assessment to be completed. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 01/08/2026, the Maintenance Director or designee will audit all facility windows two times a week for 12 weeks to ensure that the residents' windows have a screw in place to the top of the window and the bottom so that the window does not open more than 3 inches. This will be ensured by measuring with a tape measure. Any defective item or missing screws will be corrected immediately. While the repair is being completed the window will have constant monitoring by a facility staff member. The 24-hour report will be reviewed daily by the DON/designee during the clinical meeting looking for any increased wandering and/or elopement attempts. Any areas of concern identified will be immediately assessed by the Director of Nursing/designee and interventions put into place. This will be an ongoing practice. Audits of the center's response to elopement drills will be completed 1 time a week (across all shifts/days) for 12 weeks by the Maintenance Director or designee to ensure responsiveness and demonstration of the staff to properly execute procedures outlined in the Elopement and Wandering Residents Policy. On 01/09/26 an ADHOC QAPI was initiated by the Interdisciplinary Team about the event, and the	F0689		06/02/2026

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F0689 SS = SQC-J	Continued from page 13 decision was made to implement the plan with monitoring. The Administrator directed the Director of Nursing and Maintenance Director on 01/09/2026 that they are responsible for forwarding the results of their audits the QAPI Committee monthly for three months. The QAPI Committee will review the audits 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. The Medical Director was made aware of the plan on 01/09/26. IJ removal and compliance date: 01/10/2026 On 05/15/26, the corrective action plan was validated onsite through observations, record review, and staff interviews. The weekly monitoring logs of the elopement drills and observations of resident windows to ensure screws were in place at the top and bottom of the window frame were reviewed with no concerns identified. Observations of windows in resident's rooms revealed screws were placed tightly in the top and bottom of the window frame preventing them from opening more than 3 inches. Elopement binders were observed at each nurses' station and reception area that contained a picture of each resident identified as high-risk along with along with a printout of their profile page that listed pertinent identification such as age, date of birth and emergency contact numbers, a document for each resident indicating whether or not they wore an elopement device, and staff search assignments in the event of a missing person. The Social Worker confirmed she was made aware of her responsibility for maintaining the elopement binders. Interviews conducted with staff on various shifts and departments revealed they received education on the facility's elopement policy and procedure and participated in elopement drills. Staff were able to verbalize where the elopement binders were located and what information they contained, what to do when a resident demonstrated exit-seeking behaviors, and what to do in the event of a missing resident. Nurses were able to verbalize the process for completing and documenting elopement risk assessments. The IJ removal and compliance date of 01/10/26 was validated.	F0689		06/02/2026
F0656 SS = E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F0656	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #58 no longer resides in the facility. Resident #69 had activities of daily living care plans	06/15/2026

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F0656 SS = E	Continued from page 14 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and staff interviews, the facility failed to develop individualized, person-centered care plans that included areas of focus for smoking, exit-seeking	F0656	Continued from page 14 added on 5/15/2026 by the Minimum Data Set Nurse coordinator. Resident #3 had care plans added for both wandering and elopement risk on 5/15/2026 by the Minimum Data Set Nurse coordinator. Address how the facility will identify other residents having the potential to be affected by the same deficient practice Residents residing in the facility have the potential to be affected by the deficient practice. An audit was completed by the Administrator on 6/9/26 to identify any other discrepancies in care planning to include smoking, wandering, elopement risk devices and activities of daily living omissions. Any discrepancies were corrected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 6/9/26, the Minimum Data Set Nurse Coordinator and the Social Worker were educated by the Administrator to the importance of assessing/interviewing the resident and/or family, interviewing staff across all shifts, reviewing the chart to include the physician’s orders, medical provider notes, medication and treatment administration records in order to make the care plan as person centered and accurate as possible. This same education will be provided to any newly hired Minimum Data Set Nurse Coordinators and Social Workers during their orientation process by the Administrator. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Administrator or designee will audit five resident’s care plans weekly for four weeks, then three resident’s care plans weekly for eight weeks to ensure they are complete and person centered. The Administrator is responsible for forwarding the results of the audits to the Quality Assurance Performance Improvement Committee monthly for three months. The Quality Assurance Performance Improvement 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. Completion Date: 6/15/26	06/15/2026

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F0656 SS = E	Continued from page 15 behaviors, use of an elopement alarm device, and activities of daily living (ADL) for 3 of 28 sampled residents (Residents #58, #69 and #3). Findings included: 1. Resident #58 was admitted to the facility on 11/12/25 with diagnoses that included personal history of nicotine dependence, dementia with other behavioral disturbance, anxiety disorder, and depression. A Safe Smoking Screen assessment dated 11/12/25 revealed Resident #58 currently used tobacco, had no plans to stop smoking and required supervision while smoking. A Physician's Assistant (PA) admission progress note dated 11/14/25 revealed in part, Resident #58 was admitted to the facility on 11/12/25 following a hospitalization. The PA noted Resident #58 was admitted to the hospital from another skilled nursing facility (SNF) secondary to confusion and multiple attempts to elope from the previous SNF, including an incident where she climbed out of her window. Review of Resident #58's medical record revealed an active physician order dated 11/16/25 for an elopement alarm device to the right wrist due to poor safety awareness. The admission Minimum Data Set (MDS) assessment dated 11/18/25 revealed Resident #58 was not coded for tobacco use or utilizing a wander/elopement alarm. A Medical Director progress note dated 01/29/26 revealed in part, Resident #58 had a diagnosis of mild cognitive impairment of uncertain or unknown etiology and resided on the locked memory care unit. The Medical Director noted Resident #58 recently tried to elope but was found unharmed and brought back to the memory care unit. Following the incident, all safety measures were implemented to ensure the unit was locked and secure. Resident #58 had no further elopement attempts but was high risk and required continued care on the locked memory care unit. The quarterly MDS assessment dated 02/06/26 revealed Resident #58 used a wander/elopement alarm daily. Current tobacco use was not coded on the MDS assessment. Review of Resident #58's comprehensive care plans last revised on 02/26/26 revealed no care plan that	F0656		06/15/2026

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F0656 SS = E	Continued from page 16 addressed smoking, exit-seeking behaviors or use of an elopement alarm device. During an observation on 05/11/26 at 11:08 AM, Resident #58 was observed sitting outside with a staff member and another resident smoking a cigarette with no concerns noted. During an interview on 05/14/26 at 3:12 PM, the MDS Coordinator reported she currently developed all the comprehensive care plans for residents at the facility. She confirmed Resident #58 used tobacco, utilized an elopement alarm device and displayed exit-seeking behaviors as evidenced by her elopement from the facility on 01/08/26. The MDS Coordinator reviewed Resident #58's care plans and stated she should have included plans that addressed smoking, use of an elopement alarm device and exit-seeking behaviors as they were all areas that she would normally care plan and it was an oversight. During an interview on 05/15/26 at 2:22 PM, the Administrator expressed she would expect care plans to be comprehensive and accurately reflect the residents' needs. 2. Resident #69 was admitted to the facility on 07/09/25 with diagnoses that included non-Alzheimer's dementia, depression, chronic obstructive pulmonary disease (COPD), muscle weakness, and history of falling. The quarterly Minimum Data Set (MDS) assessment dated 03/06/26 indicated Resident #69 had severe cognitive impairment. He displayed no behavioral symptoms or rejection of care and wandered 4 to 6 days. He was occasionally incontinent of urine and always incontinent of bowel. He required substantial/maximum assistance with toileting hygiene, shower/bathing, putting on/taking off footwear and required partial/moderate assistance with lower body dressing and personal hygiene. He was independent with ambulation without the use of an assistive device and had one fall with minor injury during the MDS assessment look-back period. Review of Resident #69's comprehensive care plans last revised on 03/23/26 revealed no care plan that addressed his ADL needs. During an interview on 05/14/26 at 3:12 PM, the MDS Coordinator reported she currently developed all the comprehensive care plans for residents at the facility. She reviewed Resident #69's care plans and confirmed there was no care plan that addressed his	F0656		06/15/2026

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F0656 SS = E	Continued from page 17 ADL needs. The MDS Coordinator stated looking back, she should have developed a care plan that addressed the ADL areas where he needed more assistance so staff would know what level of care to provide. During an interview on 05/15/26 at 2:22 PM, the Administrator explained an ADL care plan ties into the Kardex (reference tool that contains a brief overview of a resident's daily care needs and safety precautions) which tells the nurse aides what level of care the resident required. She stated it was her expectation that ADL care plans were developed for every resident in the facility 3.Resident #3 was admitted on 2/2/24 with diagnoses that included dementia. A physician orders dated 2/7/25 included a wander alarm (a wearable electronic device that trigger door locks or alarms when a resident approaches an exit, allowing for freedom of movement within safe, monitored boundaries) to be placed on Resident #3's left lower leg and to monitor the wander alarm placement on the left lower leg every shift. A review of Resident #3's care plan last updated on 3/18/26 did not include a care plan for wandering or elopement risk. A review of Resident #3's quarterly Minimum Data Set (MDS) dated 3/27/26 coded him cognitively intact. He was not coded for having a wander/elopement alarm and had no wandering behaviors. On 5/14/26 at 3:13 PM the MDS Coordinator stated she was responsible for revising and reviewing Resident #3's care plan. She stated Resident #3 had an order for a wander alarm with a history of wandering and exit seeking and she had overlooked the order and did not care plan the resident for wandering or elopement risk. The Administrator stated on 5/15/26 at 2:30 PM Resident #3's care plan should be accurate and reflect the needs of the Resident.	F0656		06/15/2026
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F0761	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice The expired and unlabeled medications were discarded by the Director of Nursing on 5/13/2026. The items discarded were replaced and labeled.	06/15/2026

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F0761 SS = E	Continued from page 18 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §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. §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. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to date medications when opened and remove expired and unlabeled medications from 4 of 4 medication carts reviewed for medication storage (Medication Carts 100/200/300/400). The findings included: Review of the facility's medication formulary dated 2025-2026 indicated to: - discard albuterol sulfate nebulization solution in 7 days after opening foil pouch, - discard fluticasone-vilanterol 42 days after opening foil tray, - discard budesonide inhalation solution 14 days after opening foil pouch. a. On 05/13/26 at 11:30 AM an observation was conducted of the 100-hall medication cart along with Nurse #2. The observation yielded one box of albuterol sulfate nebulization solution dated 04/15/26 that was available for use. The box contained one open and undated foil pouch of albuterol sulfate solution. The observation also	F0761	Continued from page 18 Address how the facility will identify other residents having the potential to be affected by the same deficient practice Residents residing in the facility have the potential to be affected by the deficient practice. On 6/7/2026 the Director of Nursing audited 100/200/300/400 hall medication carts and ensured the medications were dated and labeled upon opening if applicable and have not passed the manufacturers recommendation for storage date. No other issues were identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 6/10/26, the Director of Nursing educated licensed nurses and medication aides regarding medication storage to include placing the open date on packaging when warranted and discarding medications after manufacturers recommended storage time has expired. Any licensed nurses or medication aides who have not received the education by 6/11/26 will receive the education prior to their next shift. The same education will be provided to any newly hired nurses and medication aids, including agency nurses and medication aids during their orientation from the Director of Nursing or Designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing or designee will conduct four random audits weekly for four weeks, three random audits weekly for four weeks, then two random audits weekly for four weeks of medication carts and medication rooms to ensure medications are dated, labeled and stored per the manufacturer's recommendations. The Director of Nursing is responsible for forwarding the results of the audits to the QAPI Committee monthly for three 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. Completion Date: 6/15/26	06/15/2026

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(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
F0761 SS = E	Continued from page 19 yielded one open and undated fluticasone-vilanterol inhalation foil tray that was available for use. The dispensed date was 03/18/26. An interview was conducted with Nurse #2 on 05/13/26 at 11:30 AM. The Nurse explained that it was the third shift nurses' responsibility to clean the medication carts which meant to clean the carts and remove the expired medications and send them back to the pharmacy. She stated the nurse who opened the package should date the medication so that the nurses would know when to discard the medication. b. On 05/13/26 at 12:09 AM an observation was conducted of the 200-hall medication cart along with Nurse #2. The observation yielded one box of albuterol sulfate nebulizing solution that was available for use. The box contained an open and undated foil pouch of the albuterol sulfate solution. An interview was conducted with Nurse #2 on 05/13/26 at 12:09 AM. The Nurse explained that it was the third shift nurses' responsibility to clean the medication carts which meant to clean the carts and remove the expired medications and send them back to the pharmacy. She stated the nurse who opened the package should have dated the medication so the nurses would know when to discard the medication. c. At 10:17 AM on 05/13/26 an observation was conducted of the 300-hall medication cart along with Medication Aide (MA) #1. The observation yielded one open and unlabeled tube of oral gel pain medication. An interview was conducted with the Medication Aide on 05/13/26 at 10:17 AM. The MA explained that she normally worked on the 300-hall medication cart when she worked and she did not know who the open tube of oral gel belonged to nor did she know how long it had been on the medication cart. d. On 05/13/26 at 9:34 AM an observation was conducted of the 400-hall medication cart along with Nurse #1. The observation yielded a box of budesonide inhalation suspension dated 02/17/26 that was available for use. The box contained one open foil pouch of budesonide vials that was not dated when opened. The observation also yielded one open and undated fluticasone-vilanterol inhalation foil tray that was available for use. The dispensed date was 02/11/26. On 05/13/2026 at 9:34 AM during an interview with	F0761		06/15/2026

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

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F0761 SS = E	Continued from page 20 Nurse #1, the Nurse explained that all the nurses were responsible for keeping the medication carts clean and orderly which included removing expired medications from the carts and returning them to the pharmacy. The Nurse stated that she did not realize that the expired medications were on the medication cart. She stated the nurse who opened the package should date the package so that the nurses would know when to discard the medication. On 05/14/26 at 2:25 PM an interview was conducted with the Director of Nursing (DON) who explained that it was the third shift nurses' responsibility to check and clean the medication carts and the first shift nurses' along with herself were to check the medication carts behind them. The DON could not recall the last time she checked the medication carts. She stated the nurse who opens the package should date the package so that the nurses would know when to discard the medication.	F0761		06/15/2026
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff and Psychiatric Nurse Practitioner (NP) interviews, the facility failed to obtain consent and inform the resident or Responsible Party in advance of the risks and benefits of psychotropic medications prior to initiation for 2 of 5 residents reviewed for	F0552	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #58 no longer resides in the facility. Resident #9 had informed consents for psychoactive medications completed on 6/9/2026 by the Director of Nursing. Address how the facility will identify other residents having the potential to be affected by the same deficient practice Residents residing in the facility that have orders for psychoactive medications have the potential to be affected by the deficient practice. The Director of Nursing completed an audit of current residents for consent of psychoactive medications on 6/9/2026. Discrepancies were corrected by 6/11/2026. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 6/9/2026, the Director of Nursing educated the nurses on the importance of obtaining consent from the resident and/or the responsible party/guardian when the resident has been ordered psychoactive medication or an increase in dose of psychoactive medication. Nurses who have not received the education will have the education prior to their next shift. Newly hired nurses including agency nurses will receive the education in orientation from the Director of Nursing or Administrator.	06/15/2026

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F0552 SS = D	Continued from page 21 unnecessary medications (Resident #9 and Resident #58). The findings included: 1. Resident #9 was admitted to the facility on 01/13/26 with diagnoses that included vascular dementia and anxiety. Review of Resident #9's admission physician orders dated 01/13/26 revealed buspirone (antianxiety medication) 15 milligrams (mg) one tablet by mouth twice a day. The admission Minimum Data Set (MDS) assessment dated 01/20/26 revealed Resident #9's cognition was moderately impaired. He displayed no behavioral symptoms and received antianxiety medications during the MDS assessment look-back period. Review of Resident #9's physician orders dated 02/08/26 indicated to increase buspirone to 15 mg one tablet by mouth three times a day. Review of the February 2026 Medication Administration Record for Resident #9 revealed buspirone was administered at 15 mg twice a day until 02/09/26 when it was increased to 15 mg three times a day through the remainder of the month of February 2026. Review of Resident #9's electronic medical record revealed no documentation that Resident #9 or the Responsible Party was informed in advance of the risks and benefits of of increasing buspirone 15 mg to three times a day on 02/09/26. On 05/14/26 at 2:30 PM an interview was conducted with the Director of Nursing (DON), who explained that Resident #9 was being followed by Psychiatry and the Psychiatry provider was responsible for obtaining informed consents from the resident or the responsible party before a psychoactive medication was initiated or increased. The DON stated Social Services was responsible for auditing the informed consents and she did not know when the last audit was completed. On 05/14/26 at 2:30 PM an interview was conducted with Social Services who explained that she had only been in her role for a few months and had never been informed that she was responsible for auditing the informed consents for the psychoactive medications.	F0552	Continued from page 21 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing or designee will audit ten residents on psychoactive medications a week for four weeks, then eight residents on psychoactive medications a week for four weeks, then five residents on psychoactive medications for four weeks to ensure that informed consents are completed for psychoactive medications. The Director of Nursing is responsible for forwarding the results of the audits to the QAPI Committee monthly for three 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. Completion Date: 6/15/2026	06/15/2026

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F0552 SS = D	Continued from page 22 An interview was conducted with the Psychiatric NP on 05/15/26 at 8:30 AM. The Psychiatric NP explained that she did not obtain informed consents for the residents' psychoactive medications and that she had never been informed that it was her responsibility to obtain informed consents. On 05/15/26 at 2:22 PM an interview was conducted with the Administrator who had only been at the facility for seven weeks. She explained that the facility was not obtaining informed consent for the psychoactive medications, but she would have expected it to be done. 2. Resident 58 was admitted to the facility on 11/12/25 with diagnoses that included dementia with other behavioral disturbance, anxiety disorder, and depression. The quarterly Minimum Data Set (MDS) assessment dated 02/06/26 revealed Resident #58 had moderate impairment in cognition. She displayed no behavioral symptoms and received antipsychotic and antidepressant medication during the MDS assessment look-back period. Review of the April 2026 Medication Administration Record (MAR) for Resident #58 revealed the following physician orders: 03/13/26: bupropion (antidepressant medication) 150 milligrams (mg) in the morning for depression and anxiety. 03/23/26 (discontinued on 04/28/26): buspirone (antianxiety medication) 10 mg two times a day for anxiety. 03/24/26: quetiapine fumarate (antipsychotic medication) 25 mg one time a day for dementia with agitation. Continued review of the April 2026 MAR revealed the medications were initialed daily by nursing staff as administered per physician orders. Review of Resident #58's electronic medical record revealed no documentation that Resident #58 or her Responsible Party were informed in advance of the risks and benefits of initiating bupropion, buspirone or quetiapine fumarate and consented to the	F0552		06/15/2026

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F0552 SS = D	Continued from page 23 treatment. During an interview on 05/14/26 at 2:25 PM, the Director of Nursing (DON) explained that Resident #58 was being followed by Psychiatry, and the Psychiatry provider was responsible for obtaining informed consent from the resident or the responsible party before a psychoactive medication was initiated or increased. The DON stated Social Services was responsible for auditing the informed consents and she did not know when the last audit was completed. During an interview on 05/14/26 at 2:30 PM, the Social Services staff member explained that she had only been in her role for a few months and had never been informed that she was responsible for auditing informed consents for psychoactive medications. During a phone interview on 05/15/26 at 8:30 AM, the Psychiatric Nurse Practitioner explained that she did not obtain informed consent for residents' psychoactive medications and had never been informed that it was her responsibility to obtain informed consents. During an interview on 05/15/26 at 2:22 PM, the Administrator reported she had only been at the facility for seven weeks. The Administrator explained that the facility was not obtaining informed consents for psychoactive medications, but she would have expected it to be done.	F0552		06/15/2026
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents	F0578	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice The code status for resident # 63 was corrected on 6/9/2026 by Director of Nursing to reflect full code in the physician order, care plan and on the Medical Orders for Scope of Treatment form. Address how the facility will identify other residents having the potential to be affected by the same deficient practice Residents residing in the facility have the potential to be affected by the deficient practice. On 5/26/26 an audit was completed by the Medical Records staff member of current residents' code status orders, care plans for advanced directives and Medical Orders for Scope of Treatment forms. Corrections were initiated on 5/26/2026. Address what measures will be put into place or	06/15/2026

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F0578 SS = D	Continued from page 24 concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to ensure code status information was accurate throughout the medical record and in locations designated by the facility for 1 of 1 resident reviewed for advance directives (Resident #63). Findings included: Resident #63 was admitted to the facility on 03/10/26. Review of the Code Status binder kept at the nurses' station on 05/11/26 at 3:45 PM revealed Resident #63 had a DNR form signed by the physician effective 03/27/25 with no expiration date. An advance directive care plan, revised 03/11/26, indicated Resident #63 was a full code. Interventions included: advanced directive would be honored as instructed and review the advance directive status periodically and as needed. Review of Resident #63's electronic medical record revealed an active physician's order dated 03/11/26 for full code.	F0578	Continued from page 24 systemic changes made to ensure that the deficient practice will not recur On 6/9/26, the Administrator educated the Minimum Data Set nurse regarding accurately documenting the residents/residents representative preferred code status in the care plan. The Director of Nursing provided education to the nurses regarding the practice of ensuring the code status documented on the Medical Orders for Scope of Treatment form matches the physician order and the advance directive care plan on 6/9/26. Nurses that did not receive the education will receive the education prior to their next shift. The Director of Nursing or Administrator will provide the education to newly hired nurses and Minimum Data Set nurses during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing or designee will audit ten residents a week for four weeks, then eight residents a week for four weeks, then five residents a week for four weeks to ensure that residents' orders related to code status, the Medical Orders for Scope of Treatment form and the care plan are correct and reflective of one another. The Director of Nursing is responsible for forwarding the results of the audits to the Quality Assurance Performance Improvement Committee monthly for three months. The Quality Assurance Performance Improvement 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. Completion Date: 6/15/26	06/15/2026

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F0578 SS = D	Continued from page 25 The admission Minimum Data Set (MDS) assessment dated 03/20/26 assessed Resident #63 with severe cognitive impairment. Review of the profile page in Resident #63's electronic medical record revealed a code status of Do Not Resuscitate (DNR). Review of Resident #69's medical record revealed a Social Services progress note dated 05/12/26 revealed a second copy of the admissions agreement and a Medical Orders for Scope of Treatment (MOST, signed medical document that translates a patient's end-of-life care preferences into actionable physician orders) was sent to Resident #69's representative by certified mail on 05/07/26. During an interview on 05/12/26 at 12:30 PM, Nurse #1 explained nurses were recently informed they were now responsible for verifying a resident's code status with the resident or their representative and getting the appropriate advanced directive forms filled out. Nurse #1 stated there were two places to look for a resident's code status, the physician order in the electronic medical record and the code status binder at the nurses' station. Nurse #1 confirmed the physician order for Resident #63 indicated he was a full code but the advanced directive in the code status binder was for a DNR. Nurse #1 stated in the event of an emergency, she was instructed to go by the resident's advanced directive filed in the code status binder. During an interview on 05/12/26 at 12:50 PM, the Director of Nursing (DON) revealed the facility utilized the MOST form and nurses were responsible for completing the form with the resident or their representative upon admission or within 48 hours. The DON explained staff could view the physician order for code status in the resident's electronic medical record or check the code status binder kept at the nurses' station. She stated the physician order and code status binder should match. The DON explained that in the event of an emergency, staff should follow the resident's advanced directive filed in the code status binder. During an interview on 05/15/26 at 2:22 PM, the Administrator stated all residents should have a completed MOST form on file. The Administrator stated the physician order and MOST form filed in the code status binder should match.	F0578		06/15/2026

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F0636 SS = D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. 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: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).	F0636	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Assessment for Resident #2 was completed after 17 days. Resident #63 had assessment completed after 16 days. Resident #58 no longer resides in the facility. Resident #9 did not have care area assessments completed. Address how the facility will identify other residents having the potential to be affected by the same deficient practice Residents residing in the facility have the potential to be affected by the deficient practice. On 6/6/2026 the Administrator reviewed section V of the MDS assessments for the last 30 days for new admissions to ensure that the nature of the problem, possible causes, contributing factors, and risk factors for the triggered care area are addressed and ensure completion in a timely manner. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 6/9/26, the Administrator educated the Minimum Data Set Coordinator, the Activity Director and the Social Worker on the importance of completing assessments in accordance with the Resident Assessment Instrument. Education was also provided regarding completing the Care Area Assessments comprehensively, addressing the underlying causes and contributing factors of the triggered care area. This same education will be provided for any newly hired Minimum Data Set Coordinator, Activity Director and Social Worker during orientation by the Administrator. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Administrator or designee will complete an audit of 4 Comprehensive Minimum Data Set Assessments per week for 4 weeks, then 2 Comprehensive Minimum Data Set Assessments for 8 weeks to ensure that they are completed timely and to ensure that the Care Area Assessments are comprehensive in addressing the underlying causes and contributing factors. The Administrator is responsible for forwarding the results of the audits to the Quality Assurance Performance Improvement Committee monthly for three months. The Quality Assurance Performance	06/15/2026

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F0636 SS = D	Continued from page 27 (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. §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. (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.) (iii)Not less than once every 12 months. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to complete admission Minimum Data Set (MDS) assessments no later than 14 calendar days after the residents' admission (Residents #2 and #63) and failed to complete Care Area Assessments (CAA) comprehensively that addressed the underlying causes and contributing factors of the triggered care area (Residents #58 and #9) for 4 of 28 sampled residents. Findings included: 1. Resident #2 was admitted to the facility on 12/30/25. Review of Resident #2's electronic medical record revealed an admission MDS assessment dated 01/09/26 that was marked as completed on 01/16/26. During an interview on 05/14/26 at 3:12 PM the MDS Coordinator verified Resident #2's admission MDS assessment was not completed within the regulatory timeframe. The MDS Coordinator explained she was out of work at the time and got behind on completing assessments. During an interview on 05/15/26 at 2:22 PM the Administrator explained admission MDS assessments should be completed within 14 days of	F0636	Continued from page 27 Improvement 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. Completion Date: 6/15/26	06/15/2026

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F0636 SS = D	Continued from page 28 the resident's admission. She stated it was her expectation for MDS assessments to be completed and submitted within the regulatory timeframes. 2. Resident #63 was admitted to the facility on 03/10/26. Review of Resident #63's electronic medical record revealed an admission MDS assessment with an Assessment Reference Date (ARD, referring to the last day of the observation period) of 03/20/26 that was marked as completed on 03/26/26. During an interview on 05/14/26 at 3:12 PM, the MDS Coordinator verified Resident #63's admission MDS assessment dated 03/20/26 was not completed within the regulatory timeframe. The MDS Coordinator explained she set the ARD wrong which was why the MDS assessment was completed late. During an interview on 05/15/26 at 2:22 PM, the Administrator explained admission MDS assessments should be completed within 14 days of the resident's admission. She stated it was her expectation for MDS assessments to be completed and submitted within the regulatory timeframes. 3. Resident #58 was admitted to the facility on 11/12/25 with diagnoses that included dementia-moderate with other behavioral disturbance, anxiety disorder, and depression. Review of the Care Area Assessment (CAA) summary from Resident #58's admission Minimum Data Set (MDS) assessment dated 11/18/25 revealed the CAA for Psychotropic Drug Use triggered for Resident #58. There was no documentation in the assessment that provided any information in the analysis of findings that described the nature of Resident #58's problem, possible causes, contributing factors, and risk factors for the triggered care area. The information in the CAA noted Resident #58 "is at risk for adverse drug reaction to the use of psychotropic medication and antidepressant" and Psychotropic Drug Use would be addressed in the care plan. Review of the CAA summary from Resident #58's admission MDS assessment dated 11/18/25 revealed the CAA for Cognitive Loss/Dementia triggered for Resident #58. There was no documentation in the assessment that provided any information in the analysis of findings that described the nature of Resident #58's problem, possible causes, contributing factors, and risk factors for the triggered care area. The information in the CAA	F0636		06/15/2026

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**

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F0636 SS = D	Continued from page 29 noted Resident #58 “has a cognitive decline per the BIMS (Brief Interview for Mental Status, a standardized screening tool used to evaluate cognition on a scale of 0 to 15) of 11” and Cognitive Loss/Dementia would be addressed in the care plan. During an interview on 05/14/26 at 3:12 PM, the MDS Coordinator reported she currently completed all the care areas assessments of the MDS except the Activities assessment. The MDS Coordinator stated the CAAs triggered by information from the MDS to help develop the care plan. She explained that the analysis of findings puts together the story of how the triggered areas (CAAs) effects the day-to-day activities and/or functioning of the residents. The MDS Coordinator acknowledged that Resident #58’s CAAs for Psychotropic Drug Use and Cognitive Loss/Dementia did not address the underlying cause or contributing factors and stated she should have written a complete CAAs for the triggered care areas. During an interview on 05/15/26 at 2:22 PM, the Administrator stated it was her expectation for the CAAs to be completed and contain a comprehensive analysis of findings for the triggered care areas. 4. Resident #9 was admitted to the facility on 01/13/26 with diagnoses that included vascular dementia and anxiety. Review of the Care Area Assessment (CAA) Summary from Resident #9’s admission Minimum Data Set (MDS) assessment dated 01/20/26 revealed the CAA for Psychotropic Drug use triggered for Resident #9. There was no documentation in the assessment that provided any information in the analysis of findings that described the nature of Resident #9’s problem, possible causes, contributing factors and risk factors for the triggered care area. The information in the CAA noted Resident #9 “is at risk for adverse drug reaction to the use of psychotropic med for anxiety. Proceed to CP (care plan).” An interview was conducted with the MDS Coordinator on 05/14/26 at 3:15 PM. She stated she currently completed all the care areas assessments of the MDS except the Activities assessment. The MDS Coordinator stated the CAAs triggered by information from the MDS to help develop the care plan. She continued to explain that the analysis of findings puts together the story of how the triggered areas (CAAs) effects the day-to-day activities and or functioning of the residents. The MDS Coordinator	F0636		06/15/2026

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F0636 SS = D	Continued from page 30 acknowledged that Resident #9's CAA for Psychotropic Drug Use was lacking in that there was no underlying cause or contributing factors and stated she should have written a complete CAA for the Psychotropic Drug Use. An interview was conducted with the Administrator on 05/15/26 at 2:22 PM. The Administrator stated it was her expectation for the CAAs to be completed and contain a comprehensive analysis of findings for the triggered care areas.	F0636		06/15/2026
F0638 SS = D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is NOT MET as evidenced by: 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 28 sampled residents reviewed (Residents #2). Findings included: Resident #2 was admitted to the facility on 12/30/25. Review of Resident #2's electronic medical record revealed a quarterly MDS assessment with an ARD of 04/03/26 that was marked as completed on 04/20/26. During an interview on 05/14/26 at 3:12 PM, the MDS Coordinator verified Resident #2's quarterly MDS assessment dated 04/03/26 was not completed within the regulatory time frame. The MDS Coordinator was unsure why Resident #2's MDS assessment was completed late and stated it was an oversight. During an interview on 05/15/26 at 2:22 PM, the Administrator explained quarterly assessments should be completed within 14 days of the ARD. She stated it was her expectation for MDS assessments to be completed and submitted within the regulatory timeframes.	F0638	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice The quarterly assessment for Resident #2 was unable to be corrected. Resident #2 still resides in the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice An audit was conducted by the Administrator on 6/10/26 of quarterly assessments completed in the last 30 days to identify any other assessments that were not completed timely. There was one finding of a resident that did not have their quarterly completed within 14 days of the assessment reference date. This resident's assessment reference date was 5/25/26 and quarterly assessment was completed 6/9/26. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 6/9/26, the Administrator educated the Minimum Data Set Coordinator, the Activity Director and the Social Worker on the importance of completing quarterly minimum data set assessments in accordance with the Resident Assessment Instrument. This education also included ensuring that the completion date is within 14 days of the assessment reference date. This same education will be provided for any newly hired Minimum Data Set Coordinator, Activity Director and Social Worker during their orientation from the Administrator. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Administrator or designee will complete an audit of six quarterly minimum data set assessments per	06/15/2026

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F0638 SS = D		F0638	Continued from page 31 week for four weeks, then four quarterly minimum data set assessments per week for eight weeks to ensure quarterly minimum data set assessments are completed timely. The Administrator is responsible for forwarding the results of the audits to the Quality Assurance Performance Improvement Committee monthly for three months. The Quality Assurance Performance Improvement 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. Completion Date : 6/15/26	06/15/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F0641	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #6 had their Minimum Data Set assessment modified on 2/27/2026 for Preadmission Screening and Resident Review. Resident #6's Assessment Reference Date was 2/13/26 but was not transmitted until 5/20/26. Resident #3 had their Minimum Data Set assessment modified on 4/10/2026 for wander guard. Resident #3's Assessment Reference Date was 3/27/26 but was not transmitted until 5/20/26. Resident #58 no longer resides in the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice Residents residing in the facility have the potential to be affected by the deficient practice. On 6/6/26 the Administrator completed a review on the current residents' most recent Minimum Data Set in the areas smoking, Preadmission Screening and Resident Review's & elopement devices to validate the most recent Minimum Data Set assessment has been coded accurately. Any assessments identified with coding errors during the review were corrected and transmitted by 6/12/26. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 6/9/26, the Administrator educated the Minimum Data Set Coordinator and Social Worker on the importance of assessing the residents and carefully reviewing all documentation in the chart during the lookback period to ensure accuracy. The education included looking under miscellaneous to review the	06/15/2026

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F0641 SS = D	Continued from page 32 §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of Preadmission Screening and Resident Review (PASRR) (Resident #6), alarms (Resident #58 and Resident #3) and current tobacco use (Resident #58) for 3 of 28 residents reviewed for accuracy of assessments. The findings included: 1. Resident #6 electronic medical record (EMR) included a Level II PASRR Determination Notification letter issued 09/12/2025 with no expiration date. Resident #6 was admitted to the facility on 02/04/26 with a cumulative diagnosis which included anxiety disorder, depression and bipolar disorder. Resident #6's admission MDS assessment dated 02/13/26 indicated Resident #6 was not currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. An interview was conducted on 05/14/26 at 3:15 PM with the MDS Coordinator who completed Resident #6's admission MDS assessment. When asked about Resident #6's admission MDS assessment and Level II PASRR status the MDS Coordinator stated she had overlooked the Level II PASRR Determination Notification letter when completing the assessment. An interview was conducted on 05/15/26 at 2:30 PM with the Administrator who stated she expected all MDS assessments to be completed accurately. 2. Resident #58 was admitted to the facility 11/12/25 with diagnoses that included personal history of nicotine dependence and dementia with other behavioral disturbance. A Safe Smoking Screen assessment dated 11/12/25 revealed Resident #58 currently used tobacco, had no plans to stop smoking and required supervision while smoking. The Treatment Administration Record (TAR) for Resident #58 revealed a physician's order dated 11/16/25 for an elopement alarm device to the right	F0641	Continued from page 32 Preadmission Screening and Resident Review, to review assessments available in the chart, such as smoking assessments, the medication administration record and the treatment administration record. This same education will be provided to any newly hired Minimum Data Set Coordinators and Social Workers during their orientation by the Administrator. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Administrator or designee will audit 10 resident Minimum Data Set assessments a week for four weeks, 8 resident Minimum Data Set assessments a week for four weeks, then 5 resident Minimum Data Set assessments a week for four weeks to ensure accuracy in the areas of Preadmission Screening and Resident Review's, smoking, and elopement devices. The Administrator is responsible for forwarding the results of the audits to the Quality Assurance Performance Improvement Committee monthly for three months. The Quality Assurance Performance Improvement 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. Completion Date: 6/15/26	06/15/2026

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

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F0641 SS = D	Continued from page 33 wrist due to poor safety awareness. The order was initialed by nursing staff as completed for each 12-hour shift on 11/16/25, 11/17/25, and 11/18/25. The admission Minimum Data Set (MDS) assessment dated 11/18/25 revealed Resident #58 was not coded for current tobacco use or use of a wander/elopement alarm. During an interview on 05/14/26 at 3:12 PM, the MDS Coordinator revealed her process for completing MDS assessments was to assess the resident, review the resident's medical record, write everything down, and then enter the information on the MDS assessment. The MDS Coordinator confirmed Resident #58 used tobacco and explained she usually looked at a resident's TAR when completing the MDS assessment but had overlooked nursing staff initialing the wander/elopement alarm device as being used by Resident #58 during the MDS assessment look-back period. During an interview on 05/15/26 at 2:22 PM, the Administrator stated she expected all MDS assessments to be completed accurately. 3. Resident #3 was admitted on 2/2/24 with diagnoses that included dementia. A physician order dated 2/7/25 included a wander alarm (a wearable electronic device that trigger door locks or alarms when a resident approaches an exit, allowing for freedom of movement within safe, monitored boundaries) to be placed on Resident #3's left lower leg and to monitor the wander alarm placement on the left lower leg every shift. A review of Resident #3's Medical Administration Record (MAR) for March 2026 noted the wander alarm was being checked every shift as ordered. A review of Resident #3's quarterly Minimum Data Set (MDS) dated 3/27/26 noted he was cognitively intact and he was not coded as having a wander/elopement alarm. On 5/14/26 at 3:13 PM the MDS Coordinator stated she had completed Resident # 3's MDS dated 3/27/26. She confirmed Resident # 3 had an active order for a wander alarm when the MDS was completed. The MDS Coordinator stated she had overlooked the order and did not code the MDS correctly. The Administrator stated on 5/15/26 at 2:30 PM MDS assessments should be accurate and Resident	F0641		06/15/2026

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F0641 SS = D	Continued from page 34 #3's wander alarm should have been coded.	F0641		06/15/2026
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff and resident interviews, the facility failed to revise a resident's care plan to indicate the development of a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident #70). The findings included: Resident #70 was admitted to the facility on 05/01/24 with diagnoses that included stage III pressure ulcer to coccyx. Review of Resident #70's wound note dated 02/27/26 revealed he had a stage III pressure wound	F0657	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #70 had the care plan updated with the presence of a pressure ulcer on 5/23/2026 by the Minimum Data Set Nurse Coordinator. Address how the facility will identify other residents having the potential to be affected by the same deficient practice Residents currently residing in the facility have the potential to be affected by the deficient practice. An audit was completed by the Administrator on 6/6/26 to ensure that current residents with pressure ulcers had care plans reflective of the pressure ulcers. Care plans were implemented, if needed. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 6/9/26, the Minimum Data Set Nurse Coordinator, Activities Director and Social Worker were educated by the Administrator on the importance of utilizing what is coded on the Minimum Data Set to review and revise the care plan. Additionally, the same should be completed with new orders, wound notes, mental health notes, physicians' notes and other documentation in the chart to ensure the care plan is comprehensive. This same education will be provided to any newly hired Minimum Data Set Nurse Coordinator, Activities Director and Social Worker during their orientation period by the Administrator. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Administrator or designee will audit five residents a week with pressure wounds to ensure their care plans are reflective of their pressure ulcers. This audit will be completed for twelve weeks. The Administrator is responsible for forwarding the results of the audits to the Quality Assurance Performance Improvement Committee monthly for three months. The Quality Assurance Performance Improvement Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine	06/15/2026

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F0657 SS = D	Continued from page 35 to his coccyx. Review of Resident #70's quarterly Minimum Data Set (MDS) assessment dated 03/31/26 revealed he was cognitively intact. Resident #70 was coded for having one or more unhealed pressure ulcers/injuries and coded as having 2 stage II pressure ulcers with one that was present upon admission. Resident #70 was also coded as using a pressure reducing device for bed and was receiving pressure ulcer care. Review of Resident #70's care plan last updated on 04/10/26 revealed no care plan or interventions for pressure ulcers. During an interview with the MDS Coordinator on 05/14/26 at 3:27 PM, she reported she was familiar with Resident #70. She also reported she was responsible for updating resident care plans quarterly or when care or significant changes occurred. The MDS Coordinator verified that when she completed his quarterly MDS assessment on 03/31/26 she coded Resident #70 as having pressure ulcers/wounds and she either missed or forgot to update Resident #70's care plan at that time to reflect the development of those pressure wounds. An interview with the Director of Nursing on 05/14/26 at 4:06 PM revealed she expected pressure ulcer/wounds to be care planned. She verified that Resident #70's care plan did not currently have a pressure ulcer/wound care plan and stated it should have been updated to reflect the pressure ulcer/wounds when Resident #70's quarterly MDS assessment was completed and indicated he had pressure ulcer/wounds. An interview with the Administrator on 05/15/26 at 8:32 AM revealed Resident #70's pressure ulcer/wounds should be noted on his care plan. She reported she felt the main reason for the completion of MDS assessments was to ensure a resident's care plan was accurate and complete.	F0657	Continued from page 35 the need for further and/or frequency of monitoring. Completion Date: 6/15/26	06/15/2026
F0687 SS = D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:	F0687	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident # 69 had his toenails cut by a physician on 5/15/26. Resident #69 was also seen by podiatry on 5/28/2026. Address how the facility will identify other residents having the potential to be affected by the same	06/15/2026

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F0687 SS = D	Continued from page 36 (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure a resident's toenails were trimmed and podiatry services were arranged for 1 of 1 resident reviewed for foot care (Resident #69). Findings included: Resident #69 was admitted to the facility on 07/09/25 with diagnoses that included non-Alzheimer's dementia, depression, chronic obstructive pulmonary disease (COPD), muscle weakness, and history of falling. The quarterly Minimum Data Set (MDS) assessment dated 03/06/26 indicated Resident #69 had severe cognitive impairment. He displayed no behavioral symptoms or rejection of care and wandered 4 to 6 days. He required substantial/maximum assistance with toileting hygiene, shower/bathing, putting on/taking off footwear and required partial/moderate assistance with lower body dressing and personal hygiene. He was independent with ambulation without the use of an assistive device and had one fall with minor injury during the MDS assessment look-back period. Review of Resident #69's comprehensive care plans last revised on 03/23/26 revealed no care plan that addressed his activities of daily living (ADL) needs. Resident #69's medical record from admission through 05/11/26 revealed no consultation reports or notations in Resident #69's medical record that he had been seen by a podiatrist. During an interview on 05/14/26 at 10:25 AM, Nurse #3 reported she was first notified of the condition of Resident #69's toenails on 05/11/26. She stated she informed the Physician Assistant who evaluated Resident #69 and provided an order for a podiatry referral. Nurse #3 stated Resident #69 usually wore socks, and she hadn't noticed the condition of his toenails previously. She explained she had not noticed Resident #69 have any issues with	F0687	Continued from page 36 deficient practice Residents residing in the facility have the potential to be affected by the deficient practice. An audit was conducted of current residents to identify any residents who need to have their toenails trimmed. This audit was conducted on 6/9/2026 by the Director of Nursing. The audit revealed that 41residents needed to have their toenails trimmed and those residents' toenails were trimmed by the nurse on 6/9/2026 and 6/10/2026. One resident refused to have their toenails trimmed. Podiatry is scheduled for 8/14/2026. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 6/9/26, the Director of Nursing educated the nurses, medication aides and certified nurse aides on the importance of proper toenail care for residents. The education included identifying residents that need toenail care and either providing the care as needed or notifying the Director of Nursing or Social Worker so that arrangements can be made to be seen by podiatry. Education included identifying when the toenail extends beyond the tip of the toe, is curved, cracked, or causing discomfort the need to trim. Any Licensed Nurse, Medication Aide or Certified Nursing Assistant who was unavailable during the education will have the education prior to their next shift. Newly hired nurses, Medication Aides and Certified Nurse's Aides will be provided the education during their orientation by the Director of Nursing or Designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Administrator or designee will audit ten residents' toenails per week for twelve weeks to ensure that the toenails are trimmed to the resident's desire. The Administrator is responsible for forwarding the results of the audits to the Quality Assurance Performance Improvement Committee monthly for three months. The Quality Assurance Performance Improvement 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. Completion Date: 6/15/26	06/15/2026

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(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
F0687 SS = D	Continued from page 37 ambulation as he often walked rapidly down the hall and he had not complained of any pain or discomfort. Nurse #3 stated that she would have thought staff would have mentioned the condition of his toenails sooner so that a podiatry referral could have been obtained for him to see the Podiatrist. Review of Resident #69's physician orders revealed an order dated 05/11/26 that read, refer to podiatry for a toenail trim. An observation of Resident #69 was conducted on 05/11/26 at 10:47 AM. Resident #69 was lying in bed, sleeping soundly, and covered with a bed sheet with his bare feet exposed. The great (big toes) toenails on both feet were thick and jagged. The toenails of the second through fifth toes on both feet were long and extended past the toenail bed. The toenails curved flat around the tip of the toes, wrapped partially around the back of the toe pad and curved inward along the mid to lower part of the toe pad. During an interview on 05/12/26 at 12:30 PM, Nurse #1 revealed she routinely provided care to Resident #69 and confirmed his toenails were thick and curved. She explained the Nurse Aides (NAs) didn't trim a resident's toenails if they were thick like Resident #69's and in those cases, an order was obtained from the provider for the resident to be seen by the Podiatrist. Nurse #1 stated she had previously put in a request with the provider for a podiatry referral (could not recall when) and was not sure why he had not been seen. Nurse #1 reviewed Resident #69's medical record and stated an order for a podiatry referral was put in yesterday (05/11/26). During an interview on 05/12/26 at 2:37 PM, NA #1 revealed she routinely provided care to Resident #69 and confirmed the toenails on both of Resident #69's feet were long and curved over the tip of the toe and around the back of the toe pads. She explained that when a resident was diabetic or had thick toenails like Resident #69, NAs did not trim the toenails. NA #1 stated the condition of Resident #69's toenails had been like that for "awhile" and she had informed the nurse (could not recall who) that he needed to see the Podiatrist for a trim. NA #1 expressed the condition of Resident #69's toenails did not appear to cause him discomfort or limit his walking but it was difficult for them to keep socks on his feet. During an interview on 05/14/26 at 9:36 AM, the Social Services staff member reported that she had	F0687		06/15/2026

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

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F0687 SS = D	Continued from page 38 been in her position a little over a month and had not been informed that Resident #69 needed to see the Podiatrist until she was notified of the podiatry referral on 05/11/26. The Social Services staff member explained when she received a podiatry referral, she contacted the podiatry group the facility utilized and filled out the necessary forms to get the resident enrolled for services and on the list to be seen at the next facility podiatry clinic. She stated she was currently working on getting Resident #69 enrolled with the podiatry group services so that he could be seen at the podiatry clinic scheduled on 05/26/26. An observation was conducted of Resident #69's toenails with the Director of Nursing (DON) on 05/14/26 at 11:10 AM. Resident #69 was lying in bed wearing gripper socks on both feet. The DON donned gloves and removed the gripper socks from both of Resident #69's feet. The DON acknowledged the great toenails on both of Resident #69's feet were thick and jagged and the toenails of the second through fifth toes of both feet were long, extended past the toenail bed and curved flat around the tip of the toes, wrapped partially around the back of the toe pad and curved inward along the mid to lower part of the toe pad. During an interview on 05/14/26 at 11:15 AM, the DON reported she was unaware of the condition of Resident #69's toenails prior to the observation. She expressed the condition of Resident #69's toenails appeared to have been in that condition for an extended time and needed trimmed. She stated the NAs trimmed a resident's toenails as part of routine care but if the resident had thick toenails or was diabetic, the resident was referred to the Podiatrist. She stated a podiatry referral for Resident #69 was obtained by the provider on 05/11/26. The DON stated staff should have noticed the condition of Resident #69's toenails when providing care and brought it to the provider's attention so that a podiatry referral could have been made sooner. During an interview on 05/15/26 at 2:22 PM, the Administrator stated she did not observe Resident #69's feet but was informed of the condition of his toenails by the DON yesterday (05/14/26). The Administrator explained that they had a Podiatrist who came to the facility to provide podiatry services for residents. She stated staff should have identified and notified the provider of the condition of Resident #69's toenails to obtain a podiatry referral. The Administrator stated she would have expected staff to have identified the condition of Resident #69's toenails upon his admission, during daily care	F0687		06/15/2026

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F0687 SS = D	Continued from page 39 or during weekly skin audits.	F0687		06/15/2026
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §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. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (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; (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 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §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. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with staff, the Physician Assistant, and the Medical Director, the facility failed to implement an order for a urinalysis with reflex to culture (a two-step urine testing method) for 1 of 2 residents reviewed with symptoms of a urinary tract infection (Resident #27). The findings included: Resident #27 was admitted to the facility on	F0690	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice On 5/18/26, the urinalysis plus culture and sensitivity were repeated for resident #27. The medical provider reviewed the results and there were no new orders. Address how the facility will identify other residents having the potential to be affected by the same deficient practice The Director of Nursing conducted an audit of laboratory orders versus lab results in the charts in the last 14 days. The provider was notified of discrepancies and an order to obtain the labs was received. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The Director of Nursing educated nurses on 6/9/2026 on the importance of following up on laboratory orders to ensure that the laboratory orders have been carried out completely, and that the results have been obtained timely. Any licensed nurse who was unavailable to receive the education by 6/9/26 was provided with the education prior to their next shift. Any newly hired licensed nurses will have the same education provided to them during their orientation by the Director of Nursing or Designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing or designee will audit five lab orders per week for twelve weeks to ensure that the orders have been carried out completely. The Director of Nursing is responsible for forwarding the results of the audits to the QAPI Committee monthly for three 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. Completion Date: 6/15/26	06/15/2026

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F0690 SS = D	Continued from page 40 11/05/25 with cumulative diagnosis of multiple sclerosis (a chronic, progressive neurological disorder), neurogenic bladder, interstitial cystitis (a condition causing persistent pelvic pressure and bladder pain), anxiety disorder and depression. The admission Minimum Data Set (MDS) assessment dated 11/11/25 and the quarterly MDS assessment dated 03/27/26 revealed Resident #27 was cognitively intact, able to be understood and understand others and had an indwelling catheter. The care plan dated 11/05/25 indicated Resident #27 as having an indwelling catheter with nursing interventions to monitor, record and report to physician any signs and symptoms of a urinary tract infection including: pain, burning, blood tinged urine, deepening of urine color, foul smelling urine, cloudiness, no output, increased heart rate, increased temperature, altered mental status, change in behaviors, change in eating habits. A Psychiatry Nurse Practitioner (NP) note dated 04/28/26 documented concern for a possible urinary tract infection contributing to the resident's mental status changes and indicated the need to rule out infection. A physician order dated 04/28/26, created by the Director of Nursing (DON) and signed by the Psychiatry NP, directed staff to collect a urine sample on 04/29/26 and send it to the lab for a urinalysis with culture and sensitivity due to Resident #27's confusion. An interview was conducted on 05/15/26 at 9:32 AM with the nurse assigned to Resident #27 on 04/29/26. Nurse #4 stated that the assigned nurse was responsible for collecting urine samples when orders were in place. Nurse #4 did not recall collecting a urine sample on 04/29/26. An interview was conducted on 05/15/26 at 10:21 AM with the DON, who stated that on 04/28/26 she entered the physician order for a urinalysis with reflex to culture, with collection beginning at 7:00 AM on 4/29/26 and ending at 6:59 AM on 04/30/26, into Resident #27's electronic health record and did not know why it was not completed. The DON stated the nurse assigned to Resident #27 was responsible for collecting urine samples. The DON revealed the order dropped off the medication administration record (MAR) after the collection time passed and was forgotten. The DON stated she expected staff to complete the order and expressed concern that an undetected urinary tract infection could result in	F0690		06/15/2026

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F0690 SS = D	Continued from page 41 sepsis. An interview was conducted on 05/13/26 at 2:30PM with the Physician Assistant (PA). The PA stated that he had ordered a urinalysis on 05/12/25 at the request of Resident #27 and was unaware of the previously missed urinalysis. After being informed that the urinalysis ordered on 04/28/26 had not been completed, the PA noted that an untreated urinary tract infection could progress to sepsis within that timeframe. Initial lab results from a urinalysis collected on 5/13/26 showed a possible urinary tract infection. A physician progress note dated 05/14/26 indicated that the urinalysis obtained the previous day showed negative nitrates and positive leukocyte esterase, the patient's vital signs were stable, and the team would await culture results before starting treatment. An interview was conducted on 05/14/26 at 11:00 AM with the Medical Director, who stated staff were expected to follow all physician orders. An interview was conducted on 05/15/26 at 2:30 PM with the Administrator, who stated all physician orders must be addressed and that the facility needed a tracking process to ensure orders were completed.	F0690		06/15/2026
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews with the resident, staff, Physician Assistant and Medical Director, the facility failed to provide pain management for a resident who reported acute, severe pain rated at a 8 out of 10 (0 meaning no pain and 10 meaning the worst pain experienced) during wound care treatment of a Stage 3 pressure ulcer. This deficient practice affected 1 of 3 residents reviewed for effective pain management (Resident #2). The findings included: Resident #2 was admitted to	F0697	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice The Director of Nursing obtained an order from the Nurse Practitioner that Resident #2 may receive pain medication as needed 30 minutes to 1 hour prior to the provision of wound care. Resident #2 is satisfied with this intervention. Address how the facility will identify other residents having the potential to be affected by the same deficient practice Residents residing in the facility that have wound care provided have the potential to be affected. On 6/9/2026 an audit was conducted by the Director of Nursing that included interviewing residents with routine wound care and having a Brief Interview for Mental Status of 12 or greater to determine if they have pain or discomfort with their wound care. Those residents who have routine wound care & have a Brief Interview for Mental Status 11 or less were observed during wound care to determine if they were exhibiting any signs or symptoms of pain	06/15/2026

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F0697 SS = D	Continued from page 42 the facility on 12/30/25 with diagnoses including obstructive uropathy, cerebrovascular accident, diabetes mellitus, depression, moisture-associated skin damage (MASD) and other specified arthritis at multiple sites. A review of the admission Minimum Data Set (MDS) assessment dated 01/09/26 and the quarterly MDS assessment dated 04/03/26 revealed that Resident #2 was cognitively intact, did not display any behaviors, was able to make her needs known, received scheduled as needed (PRN) pain medication, had pain frequently and reported that pain frequently interfered with sleep, physical therapy and day-to-day activities. The quarterly MDS assessment also coded Resident #2 for having a stage 3 pressure ulcer. Resident #2 had an active medication order with a start date of 04/20/26, for hydrocodone/acetaminophen 10 milligrams/325 milligrams (MG) (opiod pain medication combined with acetaminophen used to relieve moderate to severe pain) one (1) tablet by mouth every 6 hours, as needed for break through pain. A continuous observation of wound care treatment and resident interview were conducted on 05/12/26 at 3:05 PM until 3:20PM. During the treatment, Nurse # 2 cleansed Resident #2's wound with gauze soaked in wound cleansing solution. Resident #2 gasped with a complaint of stinging pain. The wound was approximately 3 centimeters by 3 centimeters; it appeared dark pink with a moist textured open area surrounded by a larger area of scar tissue. Nurse #2 did not respond to the complaint of pain and continued with the treatment, applying calcium alginate (highly absorbent wound dressing) and silver sulfadiazine (topical antibiotic), followed by covering with a border dressing. Resident #2 again complained of pain stating, "That hurts me". Nurse #2 did not reply and continued with care, providing a clean brief, cleaned up her supplies, and exited the room. At 3:20 PM Resident #2 stated her pain was 8 out of 10 and used her call light to request PRN pain medication. During an observation on 05/12/26 at 4:00 PM, Nurse #2 provided Resident #2 with one hydrocodone/acetaminophen 10/325 MG tablet. An interview was conducted on 05/12/26 at 4:20 PM with Nurse #2, who stated that she was often the assigned nurse for Resident #2 and completes the wound care treatment every day she works, except Fridays, when the wound care doctor was present.	F0697	Continued from page 42 or discomfort. There were no issues identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 6/9/26 the Director of Nursing educated the licensed nurses regarding the importance of informing residents prior to the start of the wound care, to let the nurse know if they are having pain during wound care. The licensed nurses were also educated to monitor for signs and symptoms of pain in residents requiring wound care, such as grimacing, groaning, moaning, etc. The licensed nurses were educated to stop the wound care if any pain was expressed or detected, then to inform the medical provider of the pain so that an intervention could be put into place and allowed time to take effect, prior to starting the wound care over again. Any licensed nurse who was unavailable to receive the education by 6/10/26 will be provided with the education prior to their next shift. Any newly hired licensed nurses will have the education provided to them during their orientation by the Director of Nursing or Designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Wound care observation of five residents a week for four weeks and then three residents a week for eight weeks will be conducted by the Director of Nursing or designee to ensure that residents are not experiencing pain secondary to wound care treatment. The Director of Nursing is responsible for forwarding the results of the audits to the Quality Assurance Performance Improvement Committee monthly for three months. The Quality Assurance Performance Improvement 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. Completion date: 6/15/26	06/15/2026

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F0697 SS = D	Continued from page 43 Nurse #2 stated that Resident #2 complained of pain when she performed the wound care treatment, which was why she always administered PRN pain medication after completing the treatment. An interview was conducted on 05/15/26 at 10:21 AM with Director of Nursing (DON), who stated when a resident reports pain during care the nurse must stop what they are doing, assess the pain, provide PRN pain medicine if available, notify physician if PRN pain medication is not available, and reassess the pain before continuing care. An interview was conducted on 05/13/26 at 2:30 PM with the Physician Assistant (PA), who stated that PRN pain medication could be administered before wound care treatment begins, but ordering it that way can be problematic for a nurse's workflow. The PA also stated that he would expect a nurse to pause wound care and administer PRN pain medication if a resident expressed pain. An interview was conducted on 05/14/26 at 11:00 AM with the Medical Director, who stated that if Resident #2 expressed pain during care she expected the nurse to stop the care, assess the pain and provide PRN pain medication if available. An interview was conducted on 05/15/26 at 2:30 PM with the Administrator, who stated if a resident complains of pain during care, she expects nurses to stop and assess the pain, notify MD, check for PRN orders, and provide available medication.	F0697		06/15/2026
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-	F0842	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #58 no longer resides in the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice Residents admitted to the facility have the potential to be affected by the deficient practice. On 6/7/2026 The Director of Nursing interviewed clinical staff who have worked in the last 14 days regarding any risk events that may have occurred. No risk events were identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 6/7/26 the Director of Nursing educated the	06/15/2026

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F0842 SS = D	Continued from page 44 (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- (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;	F0842	Continued from page 44 Licensed Nurses regarding documentation expectations required for an accurate medical record. Nurses were educated whenever a risk management note is warranted they should complete an SBAR (situation, background, assessment, and recommendation), skin assessment and/or a progress note in the residents' chart that indicates the resident has been assessed and monitored for ongoing issues as well as any other pertinent information. Licensed nurses that did not receive education by 6/9/26 will be provided with the education prior to their next shift. Newly hired nurses will receive this education in orientation from the Director of Nursing or Designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing or Designee will monitor risk management entries to ensure that the residents' chart is reflective of the issues that occurred requiring risk management documentation. This monitoring will occur four days a week for four weeks, then three days a week for four weeks, two days a week for four weeks. The Director of Nursing is responsible for forwarding the results of the audits to the Quality Assurance Performance Improvement Committee monthly for three months. The Quality Assurance Performance Improvement 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. Completion Date: 6/15/26	06/15/2026

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F0842 SS = D	Continued from page 45 (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: 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	F0842		06/15/2026

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F0842 SS = D	Continued from page 46 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 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		06/15/2026
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations	F0883	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #58 no longer resides in the facility.	06/15/2026

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

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F0883 SS = D	Continued from page 47 §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and	F0883	Continued from page 47 Address how the facility will identify other residents having the potential to be affected by the same deficient practice On 6/5/26, the Medical Records Director completed an audit of influenza and pneumococcal vaccination status for current residents. For residents identified as needing the pneumococcal vaccine the facility obtained consents or declinations and proceeded accordingly. Vaccines have been ordered for residents who consented. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The Director of Nursing or Designee educated the Licensed Nurses on 6/9/26 to ensure that the influenza and pneumococcal vaccinations need to be offered to residents who are eligible. Prior to giving the vaccinations, the following will occur: education regarding risk vs benefit will be provided, the resident/responsible party/guardian will have to sign for consent for the vaccinations, the physician's order will need to be obtained for those residents who have consents for the vaccines and the vaccination will need to be provided per the physician's order, and recorded in the residents electronic medical record. Licensed nurses that did not receive education on 6/9/26 will be provided with the education prior to their next shift. Newly hired nurses including agency nurses will receive this education in orientation from the Director of Nursing or Designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing or designee will audit 10 residents a week for 12 weeks to ensure influenza and pneumonia vaccines have been offered and education was provided. The Director of Nursing is responsible for forwarding the results of the audits to the Quality Assurance Performance Improvement Committee monthly for three months. The Quality Assurance Performance Improvement 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. Completion Date: 6/15/26	06/15/2026

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

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F0883 SS = D	Continued from page 48 (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to document that a Resident or Responsible Party (RP) were provided education regarding the benefits and potential side effects of the influenza and pneumococcal immunization or if the Resident received the influenza and pneumococcal immunization or did not receive the vaccines due to a medical contradiction or refusal. In addition, there was no documentation that the Resident was offered the influenza and pneumococcal immunization. This occurred for 1 of 5 residents reviewed for immunizations (Resident #58). The findings included: A review of the facility's policy entitled Influenza Vaccination last revised 01/01/26 read in part that Influenza vaccinations will be routinely offered from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine. Following assessment for potential medical contraindications, influenza vaccinations may be administered in accordance with physician-approved "standing orders". A review of the facility's policy entitled Pneumococcal Vaccine last revised 01/01/26 read in part that each resident will be assessed for pneumococcal immunization upon admission. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized in accordance with physician-approved "standing orders". Resident #58 was admitted to the facility on 11/12/25 with diagnoses that included chronic obstructive pulmonary disease. Review of Resident #58's quarterly Minimum Data Set (MDS) assessment dated 02/06/26 revealed the Resident's cognition was moderately impaired and did not receive the influenza vaccination because it was not offered. The MDS also indicated that Resident #58's pneumococcal vaccination was not	F0883		06/15/2026

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F0883 SS = D	Continued from page 49 up to date, and the vaccination was not offered. Review of Resident #58's electronic health record revealed no signed consent indicating the vaccines had been offered, no record of administration, or refusal documentation for the influenza and pneumococcal vaccines. Further review of the medical record also revealed no documentation of the benefits or potential side effects of the influenza and pneumococcal vaccines. An interview was conducted with the Interim Director of Nursing (DON) on 05/15/26 at 11:24 AM. The DON reviewed Resident #58's medical record and did not find any information regarding the influenza and pneumococcal vaccinations being offered, declined or that information about potential side effects was provided to the Resident or the Responsible Party. The DON explained that she could not find a history of Resident #58's vaccinations and that someone should have followed up on the immunizations after the Resident's admission to the facility. The DON stated the Regional Quality Assurance Nurse was responsible for the Infection Control Program which included immunizations. On 05/15/2026 at 11:34 AM during a telephone interview with the Regional Quality Assurance Nurse the Nurse explained that she was the Infection Control Preventionist which included immunizations. She continued to explain that the nurses were doing a good job keeping up with obtaining consent or declinations and giving the immunizations on admission, but when she looked at the immunization records during the survey, she could not find the information for Resident #58, and she did not know why. The Nurse reported the expectation was that the nurses obtain the information on admission as part of the admission procedure. She stated the Director of Nursing should have followed up with the residents who were already in house and made sure the immunizations were offered along with the benefits and potential side effects and the documentation was completed. The Regional Quality Assurance Nurse indicated that the DON knew that it was expected of her to ensure that the immunizations were done and the Regional Quality Assurance Nurse would be the final check to ensure the process was completed. The Regional Quality Assurance Nurse added, it had been a while since she had made a final check to ensure the process was completed.	F0883		06/15/2026

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F0887 SS = D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:	F0887	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Residents #2, #6 and #9 were offered the Covid 19 vaccination on 6/9/2026 and 6/10/2026. Resident #2 consented while Resident #6 and #9 declined. Address how the facility will identify other residents having the potential to be affected by the same deficient practice On 6/10/26 the Director of Nursing conducted an audit of current residents in the facility to determine who was eligible for the Covid vaccine. Residents who were eligible were offered the vaccine and gave consent or declined. Physician orders were sent to the pharmacy for those who consented to the vaccination and they will be administered on or before 6/14/26. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 6/9/26, the Director of Nursing educated the nurses regarding the policy on Covid-19 vaccinations regarding residents are to be offered the Covid-19 vaccination unless medically contraindicated. The resident/responsible party or guardian will be provided with education as to the benefits and potential side effects. The resident/responsible party or guardian will then have opportunity to consent to or to decline the vaccination. Nurses will administer the vaccination to those consented and document as such in the electronic medical record. Declinations will be documented in the electronic medical record. Licensed nurses that did not receive education by 6/9/26 will be provided with the education prior to their next shift. Newly hired nurses will receive education in orientation from the Director of Nursing or Designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing or designee will audit ten residents a week for twelve weeks to ensure the Covid vaccine has been offered and education was provided. The Director of Nursing is responsible for forwarding the results of the audits to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues	06/15/2026

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F0887 SS = D	Continued from page 51 (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and staff interviews, the facility failed to assess residents for eligibility and ensure residents were offered the COVID-19 vaccination for 3 of 5 residents reviewed for immunizations (Resident #2, Resident #6 and Resident #9). The findings included: A review of the facility's policy entitled COVID-19 Vaccination last revised 01/01/2026 read in part that COVID-19 vaccinations will be offered to resident as per Centers for Disease Prevention and Control (CDC) guidelines unless it is medically contraindicated, the individual has already been immunized or refuses to receive the vaccine. Following assessment for potential medical contraindications, COVID-19 vaccinations for residents may be administered in accordance with physician approved "standing orders". a. Resident #2 was admitted to the facility on 12/30/25. Review of the quarterly Minimum Data Set assessment dated 04/03/26 revealed Resident #2 was cognitively intact and was coded Yes, for COVID-19 immunization being up to date. Review of Resident #2's electronic medical record revealed the last COVID-19 immunization given to the Resident was 11/16/23 before her admission to the facility. There was no documentation in the medical record that indicated the COVID-19 vaccine had been offered to Resident #2 or education had been provided to Resident #2 regarding the benefits and potential side effects of the COVID-19 vaccine. b. Resident #6 was admitted to the facility on 02/04/26.	F0887	Continued from page 51 that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. Completion Date: 6/15/26	06/15/2026

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F0887 SS = D	Continued from page 52 Review of the admission Minimum Data Set assessment dated 02/13/26 revealed Resident #6 was cognitively intact and was coded No, for Covid-19 immunization being up to date. Review of Resident #6's medical record revealed no history of a Covid-19 vaccination. There was no documentation in the medical record that indicated the COVID-19 vaccine had been offered to Resident #6 or education had been provided to Resident #6 regarding the benefits and potential side effects of the COVID-19 vaccine. c. Resident #9 was admitted to the facility on 01/13/26. Review of the quarterly Minimum Data Set assessment dated 04/24/26 revealed Resident #9's cognition was severely impaired and was coded Yes, COVID-19 vaccine was up to date. Review of Resident #9's medical record revealed the last COVID-19 vaccine given to Resident #9 was 02/01/22 before admission to the facility. There was no documentation in the medical record that indicated the COVID-19 vaccine had been offered to Resident #9 or education had been provided to Resident #9 regarding the benefits and potential side effects of the COVID-19 vaccine. An interview was conducted with the interim Director of Nursing (DON) on 05/15/26 at 11:24 AM. The interim DON explained that the latest version of the COVID-19 vaccination should be offered on admission and annually. She reported that education on risk versus benefits should be offered to the resident or responsible party and they should be signing that they received this education and should be documented in the resident's medical record. The interim DON indicated the system failure was that no one continued to follow up on the immunization process to ensure that the vaccines were offered and given at the time of admission and annually afterwards. On 05/15/2026 at 11:34 AM during a telephone interview with the Regional Quality Assurance Nurse the Nurse explained that she was the Infection Control Preventionist which included COVID-19 immunizations. She continued to explain that the nurses were doing a good job keeping up with obtaining consent or declinations and giving the COVID-19 vaccine on admission, but when she looked at the immunization records during the survey, she could not find the information for Resident #2, Resident #6 and Resident #9, and she	F0887		06/15/2026

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F0887 SS = D	Continued from page 53 did not know why. The Nurse reported the expectation was that the nurses obtain the information on admission as part of the admission procedure. She stated the DON should have followed up with the residents who were already in house and made sure the COVID-19 vaccines were offered along with the benefits and potential side effects and the documentation was completed. The Regional Quality Assurance Nurse indicated that the DON knew that it was expected of her to ensure that the immunizations were done and the Regional Quality Assurance Nurse would be the final check to ensure the process was completed. The Quality Assurance Nurse added, it had been a while since she had made a final check to ensure the process was completed.	F0887		06/15/2026