| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______<br>B. WING ______ | C<br>08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>A complaint investigaton was conducted from 07/31/24 through 08/01/24. Additional information was obtained offsite through 08/07/24, therefore the exit date was changed to 08/07/24. Event ID: UHKP11. The following intakes were investigated: NC00218828, NC00219753, NC00219641, NC00219922, NC00220196, and NC00220117. 5 of the 6 complaint allegations resulted in a deficiency. | F 000 | | |
| F 580<br>SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. | F 580 | | 8/29/24 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 08/29/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 1<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff, and Nurse Practitioner interviews the facility failed to notify the medical provider of an allegation of alleged sexual abuse involving Resident #2. This affected 1 of 4 residents reviewed for abuse.<br><br>The findings included:<br><br>Resident #2 was admitted to the facility on 03/24/22.<br><br>Review of an initial allegation dated 07/25/24 at 9:16 PM read in part; staff alleged that Resident #1 stated he was sexually inappropriate with Resident #2. Resident #1 was placed on | F 580 | 1. On 7.31.2024 Nurse Practitioner was notified of allegation of abuse for resident #2 and upon assessment found no trauma.<br>2. Director of Nursing (DON) conducted an audit of events in risk management to determine the communication status with MD/NP from 7.31.24 until 8.22.24. Any cases identified as not having proper notification in place were communicated to MD/NP by the DON.<br>3. Education was conducted with Nurses, and Certified Med Aids (CMA) by Unit Manager. Education will include who needs to be notified about events and | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

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

F 580 Continued From page 2

one-on-one supervision and investigation has been initiated. The report was electronically signed by the Administrator.

Review of the daily schedule for 07/25/24 revealed that Nurse #4 and Nurse #5 were working the night shift.

Nurse #4 was interviewed via phone on 07/31/24 at 5:53 PM who explained that she was not the nurse for Resident #1 or Resident #2 that night (07/25/24) but shortly after shift change Nurse Aide (NA) #3 and NA #4 came and stated that they needed to talk in private. The two NAs reported to Nurse #4 that while giving Resident #1 a shower he reported that at night he would go into Resident #2's room and do sexually inappropriate things with her. Nurse #4 stated as soon as she finished talking to NA #3 and #4, she went to Nurse #5 who was the supervisor that evening and reported what NA #3 and #4 had reported to her. She stated that she and Nurse #5 immediately called the facility Administrator and Director of Nursing (DON).

A follow up interview was conducted via phone with Nurse #4 on 08/01/24 at 5:35 PM. Nurse #4 stated she did not call the provider and report the alleged sexual abuse because, "I did not even know that there was a reason to do that." She explained Resident #2 was unable to be interviewed and the Administrator was going to take care of everything the next day.

Nurse #5 was interviewed via phone on 08/01/24 at 9:32 AM. She stated that on 07/25/24 Nurse #4 reported to her what NA #3 and NA #4 had been told by Resident #1. Nurse #5 stated that she and Nurse #4 immediately called the facility

F 580

what type of events warrant notification. Education will be ongoing for all newly hired nurses and CMA□s and will be conducted by the nurse designated to conduct orientation. Education was completed on 8.9.2024

4. Notification audits will be completed 5 times a week for 12 weeks by Unit Manager. Audits will ensure that notifications are completed appropriately.

5. Director of Nursing will present the results of the audit tools to the Monthly QAPI Meeting for 3 months. Any trends will be identified, and further audits will be put into place as deemed appropriate.

Compliance Date: 8.29.2024

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 3 | F 580 | | |

Administrator and DON and got direction from them of what needed to be done. She stated that Resident #1 was placed on one-on-one supervision, and they obtained staff statements. She stated that she did not call the medical provider because the Administrator stated she would handle everything the next day.

The Nurse Practitioner (NP) was interviewed on 08/01/24 at 10:58 AM. The NP stated she was not notified of the alleged sexual abuse of Resident #2 until 07/31/24 when the Administrator asked for her notes, and the NP had no idea what she was talking about. The NP stated that she completed a vaginal examination on Resident #2 on 07/31/24 which showed no signs of trauma, but had she been notified she would have sent Resident #2 to the emergency for a rape kit and/or vaginal examination at the time the alleged abuse was reported.

The DON was interviewed on 08/01/24 at 12:21 PM who stated that she was contacted by the Administrator and Nurse #5 on 07/25/24 at around 9:00 PM who reported that during a shower Resident #1 alleged that he sexually abused Resident #2 at night in her room. The DON stated she spoke to NA #3 and NA #4 and had the staff place Resident #1 on one-on-one supervision. The DON stated she was not sure if the staff notified the medical provider or not, but she would have expected the provider and family or guardians to be notified of the alleged sexual abuse.

The Administrator was interviewed on 08/01/24 at 5:15 PM who stated that Nurse #4 did not contact the medical provider on 07/25/24 when Resident #1 alleged sexual abuse. The Administrator

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 4<br>stated, "I assumed the notification would be done because she knew that it was a reportable case." | F 580 | | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, resident, and staff interviews the facility failed to protect a resident's right to be free from resident-to-resident abuse when Resident #7 hit Resident #4 with a closed fist in the left eye after Resident #7 believed that Resident #4 was looking at inappropriate pictures on the shared facility computer located in the communal activity room. Resident #4 had a red area under his left eye and since the incident avoided Resident #7 and the use of the shared facility computer for approximately a week and a half which Resident #4 spent a lot of time on a daily basis. This affected 1 of 4 residents reviewed for abuse (Resident #4). | F 600 | 1. Resident # 4 and Resident #7 still reside in the facility but have been placed on separate halls. There have been no further issues. Social Worker completed psychosocial visits.<br>2. Skin assessments were completed for residents on 8.21.24 by Wound Care Nurse. There were no unexplained bruises noted. Interviews were completed for the resident with a BIMS higher than 12 by the Administrator on 8.28.2024.<br>3. Education on abuse has been conducted with current staff by Unit Manager on 8.14.2024. Education will be ongoing for all newly hired staff and conducted by the Nurse designated to | 8/29/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

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

F 600 Continued From page 5

The findings included:

Resident #4 was admitted to the facility on 11/09/12 with diagnoses that included aphasia (inability to communicate verbally).

Review of a care plan updated on 01/13/24 read, it is important to engage in daily routines that are meaningful. The goal read; Resident #4 will have opportunities to make decisions/choices related to/for self-directed involvement in meaningful activities. The interventions included: enjoy listening to music and a prefer a wide variety of music and I like to use a computer, do games, listen to music look out the window, watch television by myself and in common spaces.

Review of the quarterly Minimum Data Set (MDS) dated 06/25/24 revealed that Resident #4 had unclear speech and was usually able to make himself understood. The MDS also revealed that Resident #4 was moderately cognitively impaired and had no behaviors.

Resident #7 was admitted to the facility on 07/08/24 with diagnoses that included: metabolic encephalopathy, depressive episodes, schizophrenia, post-traumatic stress disorder, and generalized anxiety.

The admission MDS dated 07/15/24 indicated Resident #7 was moderately cognitively impaired, had signs of delirium that were present but fluctuated, had delusions, and had verbal and other behavioral symptoms 1 to 3 days during the assessment reference period.

An initial allegation report dated 07/21/24 read; Resident #4 was hit by Resident #7. Residents

F 600

conduct orientation.
4. Audits of 8 residents 5 times a week for 12 weeks will be conducted by Wound Nurse to assess skin abnormalities.
5. The Director of Nursing will present the results of the audit tools to the Monthly QAPI Meeting for three months. Any trends will be identified, and further audits will be put into place as deemed appropriate.
Compliance Date: 8.29.2024

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 600 | Continued From page 6 | F 600 | | |

were immediately separated, and Resident #4 was assessed by nursing staff with report of a reddened area at the eye. Resident #7 was placed on one-on-one supervision. Education initiated with staff. Investigation has been started. The report was electronically signed by the Administrator on 07/21/24.

A progress note for Resident #4 written by Nurse #2 dated 07/21/24 at 12:48 PM read; "[resident] was hit by another [resident] in the left eye causing a bruise [department] heads were notified."

Nurse #2 was interviewed on 07/31/24 at 11:36 AM. Nurse #2 confirmed that she was working on 07/21/24 and was taking care of Resident #4. She stated she was passing medications on the hallway where the activity room was located and heard one of the Nurse Aides (NAs) on the hall say, "whoa whoa" and look toward the activity room. Nurse #2 stated she locked her medication cart and headed down the hallway to the activity room. She stated as she approached the room Resident #7 was coming out of the door and she took his hand and began to walk down the hallway with him. Nurse #2 added that it appeared Resident #4 was exiting the activity room at the same time because his wheelchair was in the doorway. Resident #7 told Nurse #2 that Resident #4 was looking at inappropriate pictures on the internet and after he told Resident #4 to quit looking at them several times, Resident #7 hit Resident #4 in the eye. Resident #7 kept repeating the same story about ten times after the event occurred. After she got Resident #7 to his room, Nurse #2 assigned an NA to sit with him one-on-one and returned to Resident #4. Nurse #2 stated she assessed Resident #4 who was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 600 | Continued From page 7 | F 600 | | |

noted to have a 1-inch red spot to his left cheek bone area but by "the next day it was gone." Nurse #2 stated that there had been no other issues since the event occurred on 07/21/24 and stated Resident #4 just went on about his business.

An observation and interview were conducted with Resident #7 on 07/31/24 at 9:25 AM. Resident #7 was dressed in pants and a t-shirt. He was lying across his bed. Resident #7 was asked if he recalled the events of 07/21/24 and he replied, Resident #4 "was putting up raunchy pictures and I told him you are going to get us into trouble. I told him at least six to eight times that we were going to get in trouble. After I told him so many times, I grabbed him by the hair on his head and hit him in the left eye with my fist." Resident #7 was unable to recall where in the facility this occurred but stated, "the pictures were on the computer. He knew how to do the computer better than I did." Resident #7 was unable to describe the pictures except that they were "raunchy." Resident #7 stated he needed to go get his medication and could not talk anymore and exited his room and headed to the nurse's station.

An observation and interview were conducted with Resident #4 on 07/31/24 at 11:17 AM. Resident #4 was neatly dressed sitting in his wheelchair in his dark room watching television. Resident #4 was aphasic (unable to express speech) but was able to say a few words and used his hands to communicate. Resident #4 indicated he recalled the events that occurred on 07/21/24 and indicated that they occurred down the hall in the activity room. He indicated that Resident #7 had hit him in his left eye with a

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 600 | Continued From page 8 | F 600 | | |

closed fist. Resident #4 stated that it did not hurt, and the area did not swell up or bruise. When asked if he was afraid of Resident #7, Resident #4 shook his head vigorously (meaning yes) and indicated he stayed away from Resident #7. He indicated that it was all over the computer and stated that there were no inappropriate pictures on the computer. Resident #4 indicated if Resident #7 was at the computer listening to music, he (Resident #4) would go away and avoid him. When asked again if he was afraid of Resident #7, Resident #4 put his hands up and stated, "stay away" and again shook his head and stated, "oh yes."

Nurse #3 was interviewed on 07/31/24 at 11:25 AM and confirmed that she was working on 07/21/24 and was caring for Resident #7. She stated that Resident #7 was hard to redirect and wandered in/out of other residents' rooms but he enjoyed listening to music. She explained on 07/21/24 to keep Resident #7 occupied and from wandering in/out of other residents' rooms she ambulated with him to the activity room and turned on the music for him. She stated sometime later, Nurse #2 ambulated with Resident #7 from the activity room back to his room and notified Nurse #3 that he had hit Resident #4. Nurse #3 stated that she assigned an NA to sit with him one-on one and notified the facility management of what had happened. Nurse #3 stated that Resident #7 was fairly new to the facility, and she had not heard of him hitting residents before the incident or since the incident that occurred on 07/21/24. Nurse #3 stated that Nurse #2 has assessed Resident #4, and she was informed that he had a red spot under his left eye and no other injuries.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 600 | Continued From page 9<br>NA #2 was interviewed on 07/31/24 at 11:54 AM and confirmed that she was working on 07/21/24. She stated she was at the end of the hallway just outside the activity room doing her charting when she heard Resident #7 speaking loudly to Resident #4 telling him to get out and leave it alone. NA #2 stated that she could tell from the sound of Resident #7's voice that he was agitated, and she turned toward the activity room and observed Resident #7 swing his arms twice, but she could not see Resident #4 sitting in his wheelchair. She stated she hollered "whoa whoa what is going on" and she moved toward the activity room, Resident #7 and Resident #4 were coming towards her and Resident #7 stated Resident #4 was looking at bad stuff and Resident #4 was pointing to his face and indicating that he had been hit. NA #1, NA #2, Nurse #2 and Medication Aide (MA) #1 all came to assist, and the staff separated the two residents, and assigned NA #2 to sit with Resident #7. NA #2 stated she stayed with Resident #7 the remainder of her shift and then reported off to the night shift staff who was assigned to sit with him through the night. She stated that Resident #7 was apologetic about the incident but continued to insist that Resident #4 was looking at "ugly" things on the computer and they were going to get in trouble. NA #2 stated she did not see anything inappropriate on the computer that Resident #4 was looking at. She stated that Resident #4 stayed by himself most of the time and spent a lot of time in his room. She added that she had observed him in the activity room since the event and was aware that Resident #7 also spent a lot of time in the activity room as well but stated she had not seen or heard of any other problems between the two residents. | F 600 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 600 | Continued From page 10 | F 600 | | |

MA #1 was interviewed on 07/31/24 at 2:15 PM and stated she was working on 07/21/24 and was assisting a resident when she heard staff hollering for her to come to the activity room. MA #1 stated she ran towards the activity room and Resident #4 was rolling out of the activity room and she asked the NAs what had happened. Resident #7 was standing in the doorway and Nurse #2 was making her way to the area as well. Resident #4 was pointing to his face and there was a small red spot noted. Resident #7 kept saying that he told him several times to stop it, and he wouldn't. Nurse #2 took Resident #7 back to his room. MA #1 stated that under Resident #4's left eye there was a small red spot and some swelling. She added that Resident #4 was always on the computer in the activity room, but she had never seen him watch anything inappropriate.

The Unit Manager (UM) was interviewed on 07/31/24 at 2:34 PM and stated that she was not present in the facility at the time of the incident but was made aware of it when she returned to work. She explained that there was no way inappropriate things could be viewed on that computer because it was a special system designed for the elderly population. The UM stated that they placed Resident #7 on one on one after the incident but generally he was easily redirected. She added that they have made some medication adjustments, and she felt like Resident #7 had improved and was not aggressive.

The Social Worker (SW) was interviewed on 07/31/24 at 3:05 PM and stated that Resident #7 was a fairly new resident at the facility and was very confused, but she spoke to him every day

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 600 | Continued From page 11 | F 600 | | |

and had no indications of any aggression like hitting another residents. The SW stated that Resident #4 had been a resident at the facility for years and prior to the incident spent a lot of time on the computer in the activity room looking at google map images but never anything inappropriate which would be impossible because those computers were specifically designed for the elderly population. The SW stated that since the incident on 07/21/24 Resident #4 had not been going to the activity room like he did before, no one told him that he couldn't, but he chose not to. She added that she spoke to Resident #4 almost daily after the incident and had asked him if he was scared of Resident #4 and he would always say "no man."

The Activity Director was interviewed on 08/01/24 at 8:46 AM and stated that Resident #4 had been at the facility for a while, and he used to spend all his time in the activity room looking at google earth and a few other social media sites that he enjoyed. She stated that after the incident with Resident #7 on 07/21/24 Resident #4 avoided the activity room for a while and maybe in the last week she had observed him going back down there for very short periods of time. She explained that the activity room only had one computer that was part of special program of computers designed for the elderly but she had installed a device on the television in the activity room so the staff could pull up music on that device as well to ensure both residents had access to the things they enjoyed.

The DON was interviewed on 08/01/24 at 12:08 PM and stated that Resident #7 had been at the facility for a short period of time, and he was confused. Resident #7 would go to the activity

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 600 | Continued From page 12 | F 600 | | |

room and listen to music and walk around the facility and wander in/out of other rooms from time to time. The DON stated that they had adjusted some of his medications and had seen a big improvement in his behaviors. After the incident on 07/21/24 Resident #7 was on one-to-one supervision, but she did not know for how long. The DON stated that Resident #4 had been at the facility for a while and spent a lot of time in the activity room on the computer looking at land and google maps. "I don't think he has been down there as much since he got hit." She stated they had talked to Resident #4 and asked him if he had any concerns, and he stated no and indicated he felt safe at the facility. She added that as a result of the incident on 07/21/24 Resident #4 had a red spot under his left, but it faded quickly and never bruised.

The Administrator was interviewed on 08/01/24 at 12:42 PM and stated that Resident #7 had only been at the facility for a short time and that he was confused at baseline but nothing else stood out. The Administrator stated she was not in the facility on 07/21/24 when Resident #7 hit Resident #4, but she was notified that the staff had separated the two residents and made sure both were safe. The next day the Administrator met with Resident #4 and offered him a room move or facility move, and he indicated that he was fine and also told the DON he was fine and felt safe in the facility. The Administrator stated that Resident #4 was on the computer doing his usual activity and a pop up came up and Resident #7 interpreted it negatively and he hit Resident #4. Resident #7 was placed on one-on-one supervision for a couple of days and then Resident #7 was moved to a private room on another hallway. Since then, Resident #7 had

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 600 | Continued From page 13<br>shown no signs of aggression. She stated Resident #4 spent his time between his room and the activity room and she could not speak to whether Resident #4's presence was more or less in the activity since the incident on 07/21/24. | F 600 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, staff, Resident, family member and Police Detective interviews the facility failed to have systems in place to prevent illegal substances from entering the facility. This affected 2 of 3 residents (Resident #1 and Resident #3) reviewed for supervision to prevent accidents.<br><br>The finding included:<br><br>1. Resident #3 was readmitted to the facility on 07/19/24 with diagnoses that included end stage renal disease requiring hemodialysis, diabetes mellitus, diabetic retinopathy and blindness.<br><br>A review of Resident #3's care plan revised 01/19/23 revealed a vision impairment related to diagnosis of diabetic retinopathy and blindness with the goal to remain free from falls, injury and decreased socialization. The interventions utilized | F 689 | R1. Deep clean and inventory list completed by Environmental Services director by 8.26.2024 for the rooms of Resident # 3, Resident #1, and Resident # 5.<br>2. Notification will be sent via mail to families, responsible parties, Power of Attorney, and Guardians that items brought into the center will need to be inventoried and logged at the nurse's station by the attending nurse. Notification to the residents was completed 8.29.2024 through resident council by the Activities Director.<br>3. Education will be conducted Unit Manager that items brought to the center need to be inventoried by attending nurse. The audience for education will include both Nurse Aids and Nurses. Education will be completed by 8.26.2024. | 8/29/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 14<br>included giving verbal instructions and explanation, providing a clutter free environment and do not rearrange items in her room.<br><br>Review of Resident #3's quarterly Minimum Data Set (MDS) assessment dated 07/26/24 revealed the Resident was cognitively intact with highly impaired vision.<br><br>An initial allegation report dated 07/22/24 read: Resident #3 alleged that another resident entered her room and placed an illicit drug on her table. Resident #3 was sent out for further evaluation. The local police were notified and investigating. The facility was also investigating. The report was completed by the Administrator on 07/22/24.<br><br>A review of Resident #3's Emergency Department (ED) report dated 07/22/24 revealed the Resident was sent to the ED due to possible drug overdose. The Resident was unable to produce urine due to hemodialysis therefore a urine drug screen was not conducted. The report indicated the Resident had no physiological symptoms of drug toxicity.<br><br>A review of Resident #3's Emergency Department report dated 07/23/24 revealed the Resident was sent to the ED due to decreased level of consciousness and low blood pressure. A drug screen was conducted via venipuncture with no detection of illegal drugs.<br><br>An interview was conducted with Resident #3 on 07/31/24 at 5:55 PM. The Resident explained that on the evening of 07/22/24 she returned from dialysis and was sitting on the side of her bed waiting for her supper tray when the door to her room opened and a person in a wheelchair | F 689 | 4. Audit of 8 residents 2 times a week for 12 weeks will be conducted by Medical Records to confirm that inventory lists have been completed and uploaded to electronic health record.<br>5. The Director of Nursing will present the results of the audit tools to the Monthly QAPI Meeting. Any trends will be identified, and further audits will be put into place as deemed appropriate.<br>Compliance Date 8.29.2024 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 15<br>wheeled into her room and up to her over bed table which was directly in front of her. She stated she could not see who the person was because she was legally blind and could only see shadows and outlines of people and was not able to identify who the person was. Resident #3 reported that she could tell that the person was in a wheelchair by the sound it made. The Resident continued to explain that she stated "hello" several times, but the person did not respond to her. After the person wheeled up to her over bed table, she could hear that they were moving stuff around on the table and then she heard a noise that sounded as if they dropped something on the table. She stated the person then wheeled back out of the room and closed the door. Resident #3 explained she felt around on her table and found something hard and thought it was candy because people were always giving her candy. The Resident stated she smelled the item, and it did not have an odor to it, so she licked it and knew instantly that it was "meth", and it just about made her sick. The Resident explained she used to be an addict years ago and knew the taste of meth. Resident #3 reported she thought about who the person could have been that brought the meth into her room but could not figure out who it was or if it was staff or a resident, so she decided to call a family member who was a Sherrif's Deputy with the local Sherrif's department. She stated she informed her family member what had just happened, and he told her that he would send someone over and to not touch the item again but instead her family member came to the facility. Resident #3 explained that she had finished eating her supper when her family member entered her room and saw the item that she believed to be meth. She stated he put on a pair of gloves and took the meth with him to be | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 16<br>tested and instructed her not to discuss what had happened with anyone in the facility. The Resident stated that after her family member left, Resident #1 visited her in her room and could tell that she was shaken up, but she did not disclose to him what was going on. She stated that after a while several officers came back to her room while Resident #1 was still visiting and asked him to leave her room. The Resident explained that the Detective informed her that the item tested positive for meth amphetamine and was laced with fentanyl. She stated the Detective questioned her again about what happened, and she repeated the same story to the Detective. She stated that her family member wanted her to go to the emergency room to be checked out, so she went to the hospital. She reported that she was not tested for meth in the emergency room because she was on dialysis (had dialysis that day) and could not produce urine for the drug test. She stated she returned to the facility later that same night. Resident #3 voiced that she was interviewed by the Administrator and repeated her story to her about what happened. When Resident #3 was asked who she thought the person was that brought the meth into her room she replied that she did not know but she did not feel it was Resident #1 because he was a friend that visited her all the time, and she would have known by the image and sound of his wheelchair if it were Resident #1. Resident #3 explained that she used to "run" with Resident #5 who resided in the facility, when she was an addict, but she did not associate with him now. The Resident explained that she was sent out to the emergency room the following day on 07/23/24 because her blood pressure dropped, and she was tested for illegal drugs during that visit and tested negative. | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 17 | F 689 | | |

An interview was conducted with Resident #3's family member on 08/02/24 at 3:00 PM. The family member explained that he was a Sherrif's Deputy with the local police department when Resident #3 called him at 6:03 PM on 07/22/24 and reported that someone in a wheelchair came into her room and would not announce themselves after she repeatedly said "hello" to them. She stated the person was in a wheelchair and wheeled up to her bedside table and laid something on the table then rolled back out. She stated she felt for the object and thought it was candy because they were always giving her candy and she picked it up and licked it and it tasted like meth. The family member continued to explain that he told Resident #3 not to talk to anyone about what happened, and he would come over to the facility. When he arrived at the facility, he found Resident #3 sitting on the side of her bed eating supper. He asked her for the object in question and she showed him what looked like to him to be a meth rock. He stated he gloved up and removed the rock then wiped off Resident #3's bedside table and took the object to the police department to test it to determine what it was. The family member continued to explain that when tested at the police department the object was meth amphetamine and fentanyl. After testing the object, the Police Detective took over the investigation and they went back to the facility to start the investigation. The family member stated that when they got back to the facility the Detective interviewed Resident #3 then suggested she be sent to the hospital to be checked out since she reported she licked the meth rock.

An interview was conducted with the Police Detective on 07/31/24 at 4:45 PM. The Detective

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 18<br>explained that on the evening of 07/22/24 between 6:30 PM and 6:45 PM Resident #3's family member who was also a Sherrif's Deputy came to the police station to field test an object he thought was meth that was reportedly left in Resident #3 room at the facility. The rock field tested to be positive for meth amphetamine and fentanyl and would be sent to the certified laboratory for final identification which could be anywhere from 2 weeks to 2 months. The Detective continued to explain that he and several officers went to the facility to initiate the investigation and he interviewed Resident #3. The Resident stated she heard the door open, and someone wheeled up to her table and she said hello several times, but no one responded. The person wheeled back out of the room and closed the door. The Resident felt around on her table and found the rock, smelled it and it did not have a smell, so she licked it because she thought it was candy. Resident #3 stated she knew instantly it was meth because she had a history with meth and knew the taste of meth. She stated she tried to think about who could have brought the meth to her, but she stated the staff always knocked on her door and announced themselves before they entered her room, and she did not feel like it was any of her friends that were in wheelchairs because she would have recognized them by the way and sound they made when they entered her room. The Resident stated that her friend, Resident #1 visited her more often than any other resident, but she did not think it was Resident #1. The Detective reported that Resident #1 was in Resident #3's room when they returned to the facility and inquired what was going on, but they would not give Resident #1 any information. He stated when they asked Resident #1 to leave Resident #3's room, Resident #1 immediately | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 19<br>became highly nervous and anxious. Resident #3 reported Resident #1 was one of her good friends and visited her often and in fact visited her earlier in the day before she found the meth. The Detective reported he suggested to Resident #3's family member to have the Resident sent to the hospital to have her checked out and the family member advised Nurse #1 that Resident #3 would be going to the hospital. The Detective stated Resident #3 was not tested for methamphetamine at the hospital because she was on dialysis and could not produce urine for the test. He stated that he understood that Resident #3 was also tested on 07/23/24 for illegal drugs at the hospital and the test was negative. The Detective continued to explain that while still at the facility the Administrator arrived, and he explained to the Administrator what transpired with Resident #3 and the Administrator requested they bring the drug canines in for a search of the facility.<br><br>An interview was conducted with the Administrator on 07/31/24 at 12:30 PM and 2:15 PM. The Administrator explained that she received a phone call from Nurse #1 around 8:00 PM on 07/22/24 who reported that the police were at the facility and insisted on Resident #3 be sent to the hospital and that they had already called the Emergency Medical Services (EMS) but would not tell her why Resident #3 was being sent to the hospital. She continued to explain that when she got to the facility, she was not allowed to see Resident #3 but after the Resident left the facility, she was informed by the Police Detective that they found "crystal" in Resident #3's room that tested positive for meth and fentanyl. The Detective reported that Resident #3 found the meth in her room and called her family member | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 20 | F 689 | | |

who was a Sherrif's Deputy, and he came to the facility and took it to the police department and field tested it which turned out to be meth and fentanyl. The Detective stated it would have to be sent to the clinical laboratory to be confirmed. The Administrator stated at that point she requested for the police department to bring drug canines to the facility for a search for illegal drugs. The Administrator reported that when Resident #3 returned to the facility her ED report indicated that they were not able to obtain urine for drug testing, but they did assess and clear her from having any physical symptoms of a drug overdose. The Administrator stated that Resident #3 informed her that someone came into her room and did not acknowledge themselves, but she could tell that they were in a wheelchair by their shadow. Resident #3 stated the person put something on her over bed table and she picked it up and thought it was candy and licked it. The Resident reported she knew it was meth and fentanyl and at that point she called her family member. The Administrator explained she interviewed the staff about if a visitor in a wheelchair was let into the facility that night and there were no reports of a visitor in a wheelchair coming to the facility that day. The Administrator stated she requested the police department bring drug canines to the facility for an illegal drug search.

2. Resident #1 was admitted to the facility on 03/30/23 with diagnoses that included diabetes mellitus.

The quarterly Minimum Data Set (MDS) assessment dated 06/07/24 revealed Resident #1 was cognitively intact.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 21 | F 689 | | |

A review of the Emergency Department report dated 07/04/24 revealed Resident #1 tested positive for THC tetrahydrocannabinol (marijuana).

An interview was conducted with the Police Detective on 07/31/24 at 4:45 PM. The Detective explained that on the night of 07/22/24 the drug canines searched the facility for illegal drugs and the canine "hit" on Resident #1's door to his room and the Resident gave them permission to search his room which they did not find any illegal drugs in the Resident's room. The Administrator informed him that Resident #1 had a positive marijuana test on 07/04/24 when he was transferred to the hospital for medical reasons. The Detective stated the canine could have detected a smell from the marijuana since the canine could detect THC scents from up to 3 to 6 weeks. The Detective continued to explain that the Administrator reported that Resident #1 informed her that he got the marijuana from Resident #5 but when the Detective asked Resident #1 about the marijuana the Resident stated he got the marijuana from Resident #6 who was Resident #1's girlfriend who also resided in the facility. The Detective reported that the Administrator explained that early during the day on 07/22/24 a male visitor came to the facility with a dog to visit Resident #5 and signed the register but when she asked the visitor for the dog's shot records, he did not have them, so she turned the visitor away with the dog. The Detective explained that when the Administrator informed them of the visitor's name, they produced a picture of who the police thought it was and the Administrator identified the male visitor to be the person in the picture who was known to be a drug dealer in the community. He explained that the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 22 | F 689 | | |

male visitor and Resident #5 had an extensive drug history together and was well known to the local police and in fact was known to be in the area on 07/22/24. The Detective reported that the State Bureau of Investigation (SBI) was involved in the investigation related to the 07/22/24 occurrences and requested that Resident #5 not be interviewed about the incident pending the continuation of their investigation.

An interview was conducted with Resident #1 on 07/31/24 at 5:15 PM. The Resident explained that his girlfriend, Resident #6 stole a vape pen (electronic cigarette) from Medication Aide (MA) #2 on 07/02/24 and he and Resident #6 shared it on 07/02/24. The Resident continued to explain that on 07/03/24 he started feeling guilty about it and he gave the vape pen to the Social Worker. He reported that on 07/04/24 he was feeling "funny in a different way" and was sent to the hospital and was diagnosed with a urinary tract infection and he also tested positive for marijuana. The Resident stated that he first reported that Resident #5 gave it to him, but it was not Resident #5 that gave it to him.

During an interview with Medication Aide #2 on 08/01/24 at 5:35 PM the MA explained that she had not lost a vape pen nor had she had a vape stolen from her.

On 08/01/24 5:35 PM an interview was conducted with the Social Worker (SW) who explained that Resident #1 gave her a vape pen and told her that Resident #6 was vaping inside the facility. The SW stated she still had the vape pen, but it did not indicate that it had marijuana, and no one had used it to determine if it was marijuana or not.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 23 | F 689 | | |

Continued From page 23

During an interview with Resident #6 on 08/01/24 at 5:41 PM the Resident explained that she stole a vape pen off the isolation cart in the hallway that belonged to MA #2. Resident #6 stated she did not know it belonged to MA #2 until Resident #1 informed her that he had seen MA #2 with it before. Resident #6 stated she shared it with Resident #1, and it had marijuana in it, but it did not affect her the way it did Resident #1.

An interview was conducted with the Administrator on 07/31/24 at 12:30 PM and 2:15 PM and 08/01/24 at 1:00 PM. The Administrator explained that when she learned that the substance found in Resident #3's room on 07/22/24 was field tested to be meth and fentanyl she requested the police department bring drug canines in to search the facility. She stated the canine "hit" on Resident #1's room door and the Resident allowed the canine to search his room, and nothing was found. The Administrator continued to explain that she informed the police that a male visitor came to the facility earlier in the day and signed the register to visit Resident #5 and she had never seen the male visitor before that day. She stated the visitor had a dog with him, so she asked to see the dog's shot record and the visitor was unable to produce the shot record, so she turned him away from the facility. The Administrator continued to explain that she informed the Detective that Resident #1 tested positive for marijuana on 07/04/24 when he was sent to the hospital for medical symptoms. She stated she waited until 07/05/24 to question him about it and Resident #1 informed her that he ate gummies but would only disclose to her that he got them from a friend. She indicated there was talk that Resident #5 gave

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345261 | A. BUILDING ______ B. WING ______ | C 08/07/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 24 the gummies to Resident #1. She stated she received permission from Resident #5's guardian to search the room and nothing was found. When the Administrator was informed that Resident #1 reported that he did not get the gummies from Resident #5 but that it was a vape pen that was given to him by Resident #6, that was stolen from a staff member, the Administrator stated that was not what Resident #1 reported to her and that the staff member did not smoke. | F 689 | | |