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 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lotus Village Center for Nursing and Rehabilitation	**179 Combs Street , Sparta, North Carolina, 28675**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An unannounced complaint investigation was conducted on 03/17/26 with additional information collected offsite through 03/19/26. Therefore, the exit date was changed to 03/19/26. The following intake was investigated #2802783. One (1) of one (1) complaint allegation resulted in deficiency. Event ID #1F53E7-H1.	F0000		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff and Physician Assistant (PA) interviews, the facility failed to transcribe on admission an order for surgical wound care and subsequently failed to provide care to the surgical wound as ordered by the physician for 1 of 3 residents reviewed for quality of care (Resident #1). The findings included: Review of Resident #1's hospital discharge summary dated 02/20/26 revealed the following order: On the day of discharge (02/20/26) the physician opened up a small portion about 4 centimeters (cm) of the wound below the umbilicus that had some seropurulent drainage (a thin, watery, and cloudy wound exudate that appears yellowish or tan, often indicating an early or existing wound infection or inflammation) present. The discharge summary specified Resident #1 would need wet to dry dressing changes for that area of the wound with normal saline twice a day. Resident #1 was admitted to the facility on 02/20/26	F0684	Resident #1 no longer resides in the facility. Residents being admitted to the facility have the potential to be affected by the deficient practice. On 3/31/26 the residents admitted in the last 30 days had their hospital discharge summary reviewed by the Regional Nurse Consultant to ensure that orders were transcribed to the facility electronic medication administration record unless discontinued by the facility medical provider. On 3/31/26 nurses were educated by the Regional Nurse Consultant regarding transcribing orders from the hospital discharge summary to include orders that may be found in the narrative area of the summary. The education included reviewing the orders and putting them into the electronic medication administration record. Nurses that did not receive the education on 3/31/26 will not be able to work their next scheduled shift until education is completed. Newly hired nurses will receive education in orientation from the Director of Nursing. The Director of Nursing or designee will audit five newly admitted residents a week for four weeks, then four newly admitted residents a week for four weeks, then two newly admitted residents for four weeks to ensure that the hospital discharge summary orders were thoroughly transcribed to the facility electronic medication administration record. 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.	04/01/2026

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

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 03/19/2026

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
F0684 SS = D	Continued from page 1 following an exploratory laparotomy resulting in a colostomy (a surgical procedure that creates an opening (stoma) in the abdominal wall, bringing a portion of the colon to the surface to divert stool into a replaceable pouch) related to diverticulitis of the colon with perforation (occurs when an inflamed pouch in the colon wall ruptures, allowing fecal matter and bacteria to leak into the abdominal cavity, often causing severe abdominal pain, high fever, and sepsis). Review of Resident #1's progress note dated 02/20/26 at 2:42 PM written by Nurse #1 revealed the Resident was alert and oriented. The note also indicated Resident #1 did not speak English and his family was at his bedside and provided interpretation for the Resident. Review of Resident #1's physician orders dated 02/20/26 revealed no order for wet to dry dressing to the surgical wound. Review of Resident #1's Treatment Administration Record (TAR) for 02/20/26 and 02/21/26 revealed there were no orders set up to provide care for the Resident's surgical abdominal incision. Resident #1 was discharged on 02/21/26. Review of Resident #1's Discharge Minimum Data Set assessment dated 02/21/26 revealed he was discharged to home/community with return not anticipated. An interview was conducted with Nurse #1 via telephone on 03/18/26 at 3:55 PM who worked the day shift on 02/20/26 when Resident #1 was admitted to the facility. The Nurse explained that she remembered Resident #1 and that he was admitted because he had a new colostomy and was at the facility for rehabilitation. The Nurse reported she reviewed the Resident's discharge summary from the hospital to obtain the medication orders but did not read the entire summary to obtain the order for the care of his abdominal incision and therefore, did not transcribe the treatment order to the TAR. The Nurse continued to explain that she had a very busy day when Resident #1 was admitted and that the Director of Nursing (DON) helped with Resident #1's admission. The Nurse indicated that between herself and the DON the treatment order should have been transcribed. An interview was conducted with Nurse #2 on 03/17/26 at 3:15 PM who confirmed that she worked from 6:30 PM on 02/20/26 to 6:30 AM on 02/21/26. The Nurse explained that she remembered Resident #1 had a colostomy and did not speak English, but his family stayed with him all night on 02/20/26 to interpret for him. She stated	F0684	Continued from page 1 Completion date: 4/1/26	

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 03/19/2026

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
F0684 SS = D	Continued from page 2 Resident #1 slept all night. The Nurse was asked if she provided any treatment for Resident #1 and she replied that she would have to review the Resident's medical record to answer that question. When Nurse #2 was informed that there was no treatment order transcribed for the Resident's abdominal incision the Nurse repeated that she would have to review the medical record before she answered the question. An interview was conducted with Nurse #3 on 03/17/26 at 11:30 AM. The Nurse confirmed that she worked from 6:30 AM to 6:30 PM on 02/21/26. The Nurse explained that she remembered Resident #1 was admitted with a new colostomy and was to receive rehabilitation services to return home. When the Nurse was asked what the treatment was for Resident #1's abdominal incision she replied that she would have to review the medical record to answer that question. Nurse #3 indicated that she did assess Resident #1's abdominal incision but did not provide treatment for the incision. An interview was conducted with the Physician Assistant on 03/18/26 at 4:35 PM who explained that the nurses should read the entire discharge summary to obtain all discharge orders needed for the residents and not just the medication orders. The PA stated that if there were no orders for the care of the surgical incision then the facility should have called him and he would have given them orders for the incision until orders from the surgeon could have been obtained. An interview was conducted with the Director of Nursing via telephone on 03/19/26 at 10:15 AM who explained that she helped with Resident #1's admission by putting the medication orders in and she also assessed Resident #1's incision. She stated she had "skimmed" through the discharge summary when she noted the medication orders and when she saw the incision she realized that she did not see any orders for the incision care. The DON continued to explain that she was going to review the discharge summary again when she was stopped for something and forgot to review the discharge summary for treatment orders. The DON indicated the order for the incision care should have been put on the TAR so the other nurses could have performed the treatment.	F0684		
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.	F0842	Resident #1 no longer resides in the facility. Residents admitted to the facility have the potential to be affected by the deficient practice. Residents admitted for the last 30 days were reviewed by the Regional Nurse Consultant to ensure that complete and accurate documentation was in place related to the resident's admission.	04/01/2026

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 03/19/2026

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
F0842 SS = D	Continued from page 3 (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (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-	F0842	Continued from page 3 On 3/31/26 nurses were educated by the Regional Nurse Consultant regarding completing assessments and documentation on newly admitted residents. Nurses that did not receive the education on 3/31/26 will not be able to work their next scheduled shift until education is completed. Newly hired nurses will receive education in orientation from the Director of Nursing. The Director of Nursing or designee will audit five newly admitted residents a week for four weeks, then four newly admitted residents a week for four weeks, then two newly admitted residents for four weeks to ensure that the assessments and documentation is completed. 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: 4/1/26	

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 03/19/2026

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
F0842 SS = D	Continued from page 4 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff and Physician Assistant interviews, the facility failed to maintain a complete and accurate medical record related to a resident's abdominal incision and colostomy for 1 of 3 residents reviewed for complete and accurate medical records (Resident #1). The findings included: Resident #1 was admitted to the facility on 02/20/26 following an exploratory laparotomy resulting in a colostomy (a surgical procedure that creates an opening (stoma) in the abdominal wall, bringing a portion of the colon to the surface to divert stool into a replaceable pouch). Review of Resident #1’s medical record from admission on 02/20/26 to discharge on 02/21/26 revealed there were no assessments of the Resident’s abdominal incision or the new colostomy documented in the medical record. Resident #1 was discharged on 02/21/26.	F0842		

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 03/19/2026

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
F0842 SS = D	Continued from page 5 An interview was conducted with Nurse #1 via telephone on 03/18/26 at 3:55 PM who worked the day shift on 02/20/26 when Resident #1 was admitted to the facility. The Nurse explained that she remembered Resident #1, and he was admitted because he had a new colostomy. The Nurse reported that she assessed the Resident's new colostomy and abdominal incision that had a damp gauze packed in the bottom of the incision with a dry gauze over it, but she did not document her assessment in the medical record because it was late and she had intended to document the assessment the following morning. Nurse #1 continued to explain that she was notified that Resident #1 was discharged the following day and forgot to document the assessment when she returned to duty. An interview was conducted with Nurse #2 on 03/17/26 at 3:15 PM who confirmed that she worked from 6:30 PM on 02/20/26 to 6:30 AM on 02/21/26. The Nurse explained that she remembered Resident #1 he had a colostomy. Nurse #2 indicated assessments should be documented in the medical record on the residents every shift when they were admitted. The Nurse stated she did assess Resident #1 during the night by listening to his chest while he was sleeping. When asked about his colostomy and abdominal incision the Nurse remarked that she would have to refer to the Resident's medical record to answer that question. The Nurse was informed that there was no assessment documented in the medical record by Nurse #2 and she again stated she would have to refer to Resident #1's medical record before she could answer that question. An interview was conducted with Nurse #3 on 03/17/26 at 11:30 AM. The Nurse confirmed that she worked from 6:30 AM to 6:30 PM on 02/21/26. The Nurse explained that she remembered Resident #1 was admitted with a new colostomy and was to receive rehabilitation services to return home. Nurse #3 continued to explain that the facility staff documented in the medical record on the newly admitted residents once a shift which included an assessment for their reason for admission. She stated she assessed Resident #1's colostomy which was almost full and had a good seal. Nurse #3 further stated she also assessed his abdominal incision but could not describe the incision and stated to refer to her documentation. When the Nurse was shown that there was no documentation she stated she must have forgotten to document her assessment. An interview was conducted with the Regional Nurse Consultant on 03/17/26 at 1:35 PM, who explained that the new admissions should have documentation of assessments every shift until it was determined that	F0842		

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 03/19/2026

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
F0842 SS = D	Continued from page 6 they no longer required the documentation. The Regional Nurse Consultant stated she had already reviewed Resident #1's medical record and acknowledged there were no documented assessments about his new colostomy or his abdominal incision in the medical record. She stated she knew the nurses were educated to document their assessments in the medical record when they were done. An interview was conducted with the Director of Nursing (DON) on 03/17/26 at 1:40 PM who explained that she remembered Resident #1 being admitted because she looked at his colostomy, but she could not remember where it was positioned. He also had an abdominal incision, but she could not remember if it had a dressing on it. When asked where the documentation of her assessment was, she remarked that she did not document it, but she should have. The DON explained that she tried to review the residents' medical record the following morning after they were admitted for documentation and when she realized Resident #1 did not have any documentation of assessments while he was in the facility she did not follow up with the nurses to document their assessments. An interview was conducted with the Physician Assistant on 03/18/26 at 4:35 PM who indicated that he often reviewed the nurses' assessments in order to obtain information about the residents that would be beneficial for his treatment plan therefore, it was important for the nurses to document their assessments of the residents in the medical record.	F0842		