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	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lotus Village Center for Nursing and Rehabilitatio	179 Combs Street Sparta, NC 28675

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and Nurse Practitioner (NP) interviews, the facility failed to change an indwelling urinary catheter as ordered for 1 of 1 resident reviewed for urinary catheters (Resident #82). The findings included: Resident #82 was admitted to the facility on [DATE] with diagnoses that included neurogenic bladder (a condition where bladder function is disrupted due to nerve damage or malfunction, leading to problems with bladder control and emptying). Resident #82 was discharged to home on [DATE]. Review of Resident #82's discharge summary from the hospital and physician orders dated 10/13/24 indicated to change the (indwelling urinary) catheter on 11/01/24. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #82's cognition was moderately impaired and had an indwelling urinary catheter. Review of Resident #82's admission orders transcribed into the resident's medical record by Nurse #1 included an order to change the indwelling urinary catheter on 11/01/24. The care plan dated 11/01/24 revealed Resident #82 had an indwelling urinary catheter related to a neurogenic bladder. The goal to prevent skin breakdown would be prevented by utilizing interventions such as keeping the catheter anchored to prevent trauma, assisting with perineal care as needed and monitoring for skin irritation and redness. Review of Resident #82's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for the month of November 2024 revealed there was no order transcribed to the MAR or the TAR to indicate the resident's indwelling urinary catheter had been changed as ordered. An interview was conducted with Nurse #1 on 05/20/24 at 2:54 PM. The Nurse reviewed Resident #82's discharge summary and physician orders and confirmed she was the admission Nurse for Resident #82 on 10/13/24. The Nurse stated she did not know why the order for the indwelling urinary catheter change did not show up on the November 2024 MAR or TAR to be changed. Nurse #1 reported the nurses would not know to change Resident #82's indwelling urinary catheter if the order was not on the MAR or TAR to change the catheter. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted with the Director of Nursing (DON) on 05/20/25 at 3:00 PM, the DON reviewed Resident #82's admission orders and noted the order for the indwelling urinary catheter change to be done on 11/01/24. The DON looked to see if the order was processed correctly and discovered the order for the catheter change was put in the system, but Nurse #1 did not indicate for the order to be put on the MAR or TAR and therefore the order for the indwelling urinary catheter change did not show up to be done. The DON stated the nurse would not know there was an order for an indwelling urinary catheter change on 11/01/24 and acknowledged the catheter had not been changed for Resident #82 since the resident was admitted on [DATE]. An interview was conducted with the Nurse Practitioner (NP) on 05/21/25 at 10:20 AM. The NP explained that on admission to the facility, Resident #82 had a chronic indwelling urinary catheter related to a neurogenic bladder and although the Resident did not have any complications related to the indwelling urinary catheter while he was at the facility, if there was an order to change the catheter then it was her expectation for the catheter to be changed as ordered. During an interview with the Administrator on 05/22/25 at 4:15 PM, the Administrator indicated if there was an order for an indwelling urinary catheter change then she expected it to be changed.