STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345344	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camellia Gardens Center for Nursing and Rehab	**280 South Beckford Drive , Henderson, North Carolina, 27536**

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F0000	INITIAL COMMENTS The survey team entered the facility on 11/12/25 to conduct a complaint investigation survey. The survey team was onsite 11/12/25 through 11/13/25. Additional information was obtained remotely on 11/14/25 though 11/18/25. The survey team returned to the facility on 11/19/25 to validate the credible allegation of immediate jeopardy removal and exited on 11/19/25. Additional information was obtained remotely on 12/3/25. Therefore, the exit date was changed to 12/3/25. The following intake was investigated: 2665354. This intake resulted in immediate jeopardy. 1 of the 6 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 10/21/25 and was removed on 11/14/25. A partial extended survey was conducted.	F0000		12/20/2025
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following:	F0628	On 12/21/25, Resident #1 medical record was amended with a late entry to document his change in condition on11/10/25. On 12/17/25, an audit of residents transferred or discharged to the hospital from the facility within the past 30 days was initiated by the Regional Nurse Consultant, Director of Nursing, and/or unit manager to ensure documentation of a change in condition was completed. The audit will be completed by 12/20/25. Any concerns identified during the audit were corrected by the Regional Nurse Consultant, Director of Nursing (DON), and unit manager. On 12/17/25, an in-service for nurses was initiated by the unit manager and/or Director of	12/21/2025

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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F0628 SS = D	Continued from page 1 (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	F0628	Continued from page 1 Nursing regarding nurses must document residents change in condition to include when a resident has an acute change that results in a transfer to the hospital. The in-service will be completed by 12/20/25. After 12/20/25, any nurse that has not received the in-service will be educated prior to the next scheduled shift. Newly hired nurses will be educated during orientation by the Director of Nursing. The Director of Nursing (DON) and/or designee will review five residents that have been transferred or discharged to the hospital for twelve weeks utilizing the discharge audit tool to ensure documentation for a change in condition was completed. Any concerns identified will be immediately addressed and corrected by Director of Nursing to include providing additional re-training as appropriate. The Director of Nursing will review the discharge audit tool weekly for twelve weeks to ensure all concerns are addressed. The Director of Nursing or designee will forward the results of the audit to the QAPI Committee monthly for 3 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.	

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F0628 SS = D	Continued from page 2 (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a	F0628		

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F0628 SS = D	Continued from page 3 mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written	F0628		

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F0628 SS = D	Continued from page 4 notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). 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 failing to document a resident’s change in condition requiring Emergency Medical Services (EMS) interventions for 1 of 1 resident reviewed for hospitalization (Resident #1). The findings included: Resident #1 was admitted to the facility on 8/27/21 with diagnoses that included chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD). Review of Resident #1’s medical record revealed there was no documentation of a change in condition requiring a transfer to the hospital on 11/10/25. The Emergency Department Discharge Summary dated 11/11/25 revealed Resident #1 was seen for flash burn. Resident #1 was on 3 liters of oxygen for end stage COPD. Resident #1 was smoking a cigarette while he had oxygen on and experienced a flash burn. Resident #1 was not in pain and did not have any trouble breathing. Resident #1 had singed nose hair in both nares (nostrils) and a burn to the upper left lip with dermis exposed.	F0628		

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F0628 SS = D	Continued from page 5 An interview was conducted with Nurse #2 on 11/13/25 at 10:31 AM, she stated she was the nurse on duty on the night of 11/10/25 when Resident #1 received a burn from smoking a cigarette with his oxygen on. Nurse #2 stated Medication Aide #1 came and notified her that Resident #1 was smoking and had caught fire. Nurse #2 stated she observed Resident #1's mustache was burnt, the smile lines to both sides of his mouth looked red and fleshy, and his forehead had a burn mark. Nurse #2 stated she called Emergency Medical Services (EMS) and Resident #1 was transferred to the local hospital. Nurse #1 stated she did not document the incident in the electronic medical record. An interview was conducted with the Administrator on 11/18/25 at 3:30 PM. The Administrator reviewed the nurse progress notes for 11/10/25. The Administrator confirmed there was no documentation for the 3:00 PM to 11:00 PM shift on 11/10/25.	F0628		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §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.	F0656	On 12/03/25, the Minimum Data Set (MDS) Coordinator updated the care plan for Resident #4 to reflect independent smoking status. On 12/03/2025 the Administrator educated the Minimum Data set Nurse to ensure that care plans are updated to reflect the resident current smoking status. On 12/03/25, the Minimum Data Set Nurse completed an audit of current residents' most recent smoking assessments to ensure a care plan to address smoking had been completed and accurate for current smoking status. There were no additional concerns identified during the audit. On 12/03/25, Regional Nurse Consultant and Administrator initiated an in-service with Minimum Data Set Nurse regarding smoking care plans with emphasis on the responsibility of the Minimum Data Set Nurse to ensure care plans are updated to reflect the residents' current smoking status. The in-service will be completed by 12/20/25. The Director of Nursing and/or designee will utilize the Resident smoking audit tool to review smoking assessments on five smoking residents including Resident #4 weekly for twelve weeks to ensure smoking assessments have a care plan updated to reflect the residents' current smoking status. Any identified concerns will result in immediate corrective action and reported to the Administrator.	12/21/2025

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F0656 SS = D	Continued from page 6 (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 observation, record review and staff interview, the facility failed to develop a comprehensive person-centered care plan to address smoking for 1 of 5 sampled residents (Resident #4). Based on observation, record review and staff interview, the facility failed to develop a comprehensive person-centered care plan to address smoking for 1 of 5 sampled residents. (Resident #4) The findings included: Resident #4 was admitted to the facility on 9/28/25. The Safe Smoking screen dated 9/28/25 revealed Resident #4 was safe to smoke independently (unsupervised). The Admission Minimum Data Set (MDS) dated 10/4/25 revealed Resident #4 was cognitively intact and used tobacco. Resident #4 transferred independently and ambulated independently. An observation was conducted of Resident #4 smoking a cigarette on 11/12/25 at 1:32 PM. Resident #4 was standing in the employee parking lot by the back of the facility. There were no other residents present. This area contained a fireproof smoking receptacle. As of 11/12/25, Resident #4 had no care plan related to	F0656	Continued from page 6 The Director of Nursing or designee will forward the results of the audit to the QAPI Committee monthly for 3 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.	

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F0656 SS = D	Continued from page 7 smoking. An observation was conducted on 11/13/2025 at 3:35 PM. Resident #4 was observed outside of the facility on the left side of the building (if facing the front door from the outside) approximately 100 feet away from the designated smoking area. On 11/13/25 a care plan was initiated related to smoking for Resident #4 that indicated the resident wished to smoke and was assessed as an independent smoker. The interventions included to complete a smoking assessment and reassess quarterly, annually, and with a change of condition that affects the ability to smoke; orient to the facility's designated smoking areas; and provide education on safe smoking practices and review smoking policy with the resident. During an interview with Confidential Source #2 on 11/14/25 at 12:11 PM they (Confidential Source #2) stated they had observed Resident #4 smoking cigarettes on multiple occasions. Confidential Source #2 indicated they specifically recalled an observation in early October 2025 but were unable to recall the other observation dates. Confidential Source #2 stated they did not want the facility to know their identity due to fear of being fired. A phone interview was conducted with the MDS Coordinator on 12/3/25 at 10:30 AM. The MDS Coordinator indicated she had never seen Resident #4 smoking prior to 11/13/25. She explained she observed Resident #4 smoking on 11/13/25 and that was when she initiated a care plan related to smoking. The MDS Coordinator indicated that to her knowledge, no other staff had observed Resident #4 smoking prior to 11/13/25. A phone interview was conducted with the Director of Nursing (DON) on 12/3/25 at 10:32 AM. The DON reviewed Resident #4's care plan and verified that a smoking care plan was not initiated until 11/13/25. The DON stated once the facility learned through observation that Resident #4 smoked, a smoking care plan was initiated. The DON stated Resident #4 had denied smoking when she reviewed the smoking policy with all residents that had Safe Smoking Screening Assessments in late October 2025. An interview was conducted with the Administrator on 12/3/25 at 11:04 AM. The Administrator stated that Resident #4 should have been planned for smoking once he was deemed a safe smoker.	F0656		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices	F0689	On 11/10/25, Resident #1 was immediately assessed for	12/21/2025

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F0689 SS = SQC-J	Continued from page 8 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: Based on observation, record review, and interviews with resident, Medical Director, and staff, the facility failed to provide effective supervision to Resident #1, who was deemed unsafe to smoke without supervision and had known non-compliance with the smoking policy, to prevent the resident from smoking while utilizing his portable oxygen tank. On 10/20/25, 10/21/25, and 11/6/25 Resident #1 exited the facility independently and was seen by staff smoking in undesignated smoking areas with his portable oxygen tank present and in use via nasal cannula. The oxygen tank was removed by staff and no harm was caused to the resident on these dates. On 11/10/25 Resident #1 again exited the facility independently and was seen by staff smoking in an undesignated smoking area with his portable oxygen tank present and in use via nasal cannula while Resident #2 was present in the area. Resident #1 stated he lit his cigarette, it “flamed up”, and he dropped the cigarette and oxygen tubing with nasal cannula onto the ground to stomp out the flame with his foot. Dietary Aide #1 walked by and saw Resident #1’s shirt catch fire, she informed the resident, and he took his shirt off to extinguish the flame. Resident #1 was sent to the Emergency Department (ED) for evaluation and identified to have sustained a flash burn (occurs when a lit cigarette ignites the oxygen-saturated air around a person using supplemental oxygen, causing a rapid, intense fire on the face and nose) resulting in singed nose hair in both nostrils and a burn to the upper left lip with the dermis (the inner of the two main layers of skin containing connective tissue, blood vessels, oil and sweat glands, nerves, hair follicles, and other structures) exposed. Supplemental oxygen devices produce enriched oxygen which accelerates combustion; smoking near oxygen devices is a fire hazard and has a high likelihood of resulting in serious harm to all persons nearby from	F0689	Continued from page 8 injuries and taken to the hospital for further evaluation. On 11/11/2025, Resident #1 was placed on 1:1 Supervision to prevent reoccurrence of smoking with portable oxygen. Residents that smoke have the potential to be affected by the deficient practice. On 11/11/25, residents who smoke were re-assessed for smoking safety. This assessment is to identify a resident’s ability to smoke safe/independently or who require supervision. The care plan was updated as applicable for current residents’ smoking status following the assessment. On 11/11/25, the Administrator, Unit manager, Minimum Data Set nurse, and/or Director of Nursing educated current residents who smoke on the smoking policy to include Resident #1 on not accepting or asking for any cigarettes, vapes, lighters, and/or other smoking paraphernalia from another resident or Visitors; to include smoking in designated smoking areas. Education will be completed by 12/20/2025. On 11/11/25, the Administrator, Unit Manager, and/or Director of Nursing initiated an in-service with current staff regarding: Use of smoking items (including vapes) /is /only allowed to be used in the designated smoking area located under the canopy with picnic tables. Smoking materials (including vapes) /must be always secured/locked. If you see any lock boxes unsecured, notify management /immediately. Residents /and staff /are NOT ALLOWED to /share smoking materials between each other. Weather /permitting, smoking times are as follows: /10am, 1pm, 4pm, and 6pm. ALL smokers MUST abide by the same designated smoking /area	

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F0689 SS = SQC-J	Continued from page 9 fire and/or an explosion. Additionally, the facility failed have an effective system in place to ensure: the smoking policy was followed; interventions were developed and/or implemented to address unsafe smoking practices; residents with known non-compliance with the smoking policy were monitored to prevent non-compliance from continuing; and supervision was provided for residents who were assessed as unsafe smokers. This deficient practice affected 5 of 5 residents (Residents #1, #2, #5, #4, and #3) reviewed for smoking. Immediate jeopardy began on 10/21/25 when the facility failed to implement effective interventions to prevent a repeat incident of Resident #1 smoking with his portable oxygen tank in use. Immediate jeopardy was removed on 11/14/25 when the facility implemented a credible allegation of immediate jeopardy removal. Example #2 was cited at scope and severity of E. The facility will remain out of compliance at a lower scope and severity level E (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure monitoring of systems are put in place, to complete employee in-service training, and to correct deficient practice for Example #2. The findings included: The facility's smoking policy last revised 10/22/24 indicated the following: Smoking was prohibited in all areas except the designated smoking area and safety measures for the designated smoking area included the prohibition of oxygen use. All residents were asked about tobacco use during the admission process and during each quarterly or comprehensive minimum data set (MDS) assessment process. Residents who smoked would be assessed using the Resident Safe Smoking Assessment to determine if resident is safe to smoke at all. Any resident who is deemed safe to smoke, will be allowed to smoke in designated smoking area and in accordance with his/her care plan and all safe smoking measures will be documented on each resident. If a resident did not abide by the smoking policy or care plan, the plan of care may be revised to include additional measures such as prohibited smoking, or even discharge. Smoking materials for residents who smoke were to be maintained by nursing staff. On 11/12/25 at 1:18 PM, an observation was conducted of the designated smoking area that was located to the left of the front entrance to the building. The designated smoking area had a canopy and included ash trays, smoking receptacles, fire blankets, fire	F0689	Continued from page 9 Supervised smokers must have staff present in the designated area /during designated smoking times. Supervised smokers /that are /care planned to wear aprons, MUST always wear aprons while smoking. Oxygen /cannot be in designated smoking /areas (take off prior to exiting /building). Fire blanket is hanging on pole in designated smoking area. Proper smoking receptacles /must be always utilized /in the designated smoking area. Residents that smoke will be assessed for risk of unsafe smoking practices upon admission by the admitting nurse or nurse manager and as needed throughout their stay if a risk is /identified. /Example: change in /residents' mental status. It is mandatory to notify nurses /regarding /changes in resident /conditions. Supervised and unsupervised smoking binders are kept at each /nurse's /station and front desk. If you see a resident smoking outside of the designated area, residents should be redirected to /designated /area if an unsupervised smoker. /Notify leadership after redirection. If you see a supervised smoking resident smoking without supervision, /immediately /notify nurse and leadership. Nurses and assigned CNA must check the smoking binders daily, prior to taking residents out to smoke. Staff MUST remove oxygen prior to residents' exiting facility until residents return inside. If /residents refuse, staff MUST stay with residents outside to	

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F0689 SS = SQC-J	Continued from page 10 extinguisher and fireproof waste bins. 1. Review of the user's manual intended use for Resident #1's portable oxygen tank revealed the portable oxygen tank supplied a high concentration of oxygen and is used with a nasal cannula to deliver oxygen from the oxygen cylinder to the patient. General precautions included a warning which stated this device produces enriched oxygen gas which may cause or intensify fire if it comes in contact with combustible materials, open flames, or sparks and contains gas under pressure that can explode if heated. Smoking and any open flames are strictly forbidden within 5 feet of the cylinder while oxygen therapy is in use. Resident #1 was admitted to the facility on 8/27/21. His diagnoses included chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD). Resident #1's Smoking Screening's dated 10/11/24 and 12/19/24 indicated he was not a smoker. A physician order dated 12/19/24 revealed an order for continuous oxygen therapy at 3 liters per minute (lpm) via nasal cannula every shift every day. The Quarterly Minimum Data Set (MDS) Assessment dated 3/29/25 revealed Resident #1 was cognitively intact, required supervision with 1-person physical assist for bed mobility, transferred independently with setup help only, used a walker for mobility, and was on oxygen therapy. The Safe Smoking Assessment dated 6/20/25 completed by Unit Manager #1 revealed Resident #1 was a smoker and used smokeless tobacco. The resident had no history of smoking related incidents. He smoked 1-2 times a day. Resident #1 did have dexterity problems or tremors. The resident was on supplemental oxygen and could be without supplemental oxygen during smoking times. Resident #1 ambulated independently and required supervision while smoking. Resident #1's care plan initiated 7/10/25 revealed the resident was a supervised smoker and the goal was for Resident #1 to be supervised at all times while smoking. There was no documentation of noncompliance in the care plan. The interventions included staff assisting and supervising resident on smoking times. A Nursing Progress Note completed by Nurse #3 dated 7/12/2025 revealed Resident #1 goes outside to smoke with oxygen tank. Resident is non-compliant.	F0689	Continued from page 10 ensure smoking does not occur. Residents placed /on /1:1 MUST always have staff with them. Relief must arrive prior to using restroom, break, leaving at end of shift, etc. If you see a resident smoking with oxygen, /IMMEDIATELY /have resident extinguish /cigarette /then remove or turn off oxygen. Immediately notify assigned nurse and leadership /after; /without leaving /the resident. Failure to notify leadership can result in disciplinary action up to termination. Newly hired staff will be educated during orientation by the Administrator and/or Director of Nursing. The in-service will be completed by 12/20/2025. The interdisciplinary Team will review smoking assessments of five residents who smoke or desire to smoke weekly for twelve weeks; utilizing the Smoking Audit Tool. This audit is to ensure the residents are assessed for smoking safety with education on smoking policy to include storage of smoke paraphernalia, smoking times and designated areas, and care plan updated to accurately reflect smoking status and oxygen use. The Director of Nursing and/or designee will address concerns identified during the audit and Notify the Administrator. The Director of Nursing and/or Administrator will review the Smoking Audit Tool weekly for twelve weeks to ensure concerns were addressed. The Director of Nursing or designee will forward the results of the audit to the QAPI Committee monthly for 3 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.	

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F0689 SS = SQC-J	Continued from page 11 Multiple attempts to contact Nurse #3 for interview were unsuccessful. The record indicated Resident #1 was discharged to the hospital on 10/13/25 for acute hypoxic respiratory failure due to right lower lobe and left middle lobe pneumonia. Resident #1 was readmitted to the facility on 10/17/25. A physician's order dated 10/17/25 indicated the previous order for continuous oxygen at 3 lpm was changed to 5 lpm via nasal cannula for respiratory failure. An Admission/Readmission Screening for smoking dated 10/17/25 indicated resident was a smoker and on 5 lpm of O2 via nasal cannula. During an interview with Confidential Source #2 on 11/14/25 at 12:11 PM it was stated Resident #1 had been seen by Confidential Source #2 on 10/20/25 and 10/21/25 smoking with his oxygen tank present and oxygen in use via nasal cannula around other residents in non-designated smoking areas. Confidential Source #2 stated he or she removed the oxygen tank from Resident #1 and placed the tank inside the building. Confidential Source #2 stated they had reported these 2 specific incidents with Resident #1 to the Administrator and DON. Confidential Source #2 stated nothing was ever done about residents smoking in unauthorized areas. Confidential Source #2 stated no new interventions were implemented. Confidential Source #2 they did not want the facility to know their identify due to fear of being fired. Resident #1's care plan revised on 10/21/25 revealed the resident was a supervised smoker and the goal was for Resident #1 to be always supervised during smoking times. The interventions included staff to assist Resident #1 outside at smoking times and to remove oxygen prior to entering the designated smoking area. There was no documentation about noncompliance included in the care plan. During an interview with Nurse #1 on 11/12/25 at 1:10 PM, she stated the facility had scheduled times for residents who required supervision to smoke. Nurse #1 indicated that assigned staff went outside with the supervised residents who smoked. She further stated that the residents that didn't require supervision were able to go out anytime as long as the residents let the	F0689		

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F0689 SS = SQC-J	Continued from page 12 staff know. Nurse #1 stated cigarettes were kept in the medication room in a lock box and the nurse gave the residents 1 cigarette at a time for the unsupervised residents. Nurse #1 indicated residents were only to smoke in the designated smoking area at the side of the building. Nurse #1 stated she was familiar with Resident #1 and he was a smoker. Nurse #1 stated Resident #1 was not a smoker when he was admitted in 2021. She stated Resident #1 used to smoke but had quit. Nurse #1 stated that after 3 years Resident #1 picked up smoking again. She explained that she had been informed by other staff that Resident #1 began smoking again after the death of a loved one. Nurse #1 stated Resident #1 had been assessed for smoking on 6/20/25 and determined to require supervision. Nurse #1 stated an intervention of removing oxygen prior to entering designated smoking area was added to Resident #1's care plan on 10/21/25 because he kept taking his oxygen tank outside when he went to smoke. She explained she heard about staff having to remind Resident #1 to leave his oxygen inside when going to smoke about five times between July 2025 to October 2025. She was unable to recall who these staff were. She further explained she had redirected Resident #1 to leave his oxygen tank inside once in October 2025 when she saw him coming to the backdoor as she was entering at that door to begin her shift. Nurse #1 stated this back door exit did not lead to the designated smoking area. Nurse #1 explained that Resident #1 had a cigarette that was not lit in his hand and was pulling his oxygen tank in his oxygen tank holder. Nurse #1 stated she removed the resident's nasal cannula and oxygen tank and placed the tank inside the building. Nurse #1 stated she retrieved the cigarette from Resident #1 and he did not go out to smoke at that time to her knowledge. Nurse #1 stated she had only witnessed the resident attempting to go outside with a cigarette and oxygen that single time. Nurse #1 indicated an intervention was added to the resident's care plan to remove his oxygen prior to entering the designated smoking area. Nurse #1 stated she had spoken to Resident #1 about the dangers of smoking with oxygen on multiple occasions and he was dismissive. She reported that she had talked with Resident #1 about how he could set himself on fire, cause an explosion in the building, and how he could cause injury to other residents. Nurse #1 stated she felt the resident understood what she was saying but he showed a lack of concern about it. She further stated Resident #1 tended to "slip away at times" and smoke without supervision. She indicated since Resident #1 ambulated independently he was able to go outside without being noticed. There was no intervention implemented for increased monitoring of Resident #1 to ensure he was supervised	F0689		

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F0689 SS = SQC-J	Continued from page 13 while smoking. Nurse #1 added that Resident #1 was allowed to go outside without supervision and not smoke. The Annual MDS Assessment dated 10/22/25 indicated Resident #1 was cognitively intact. He was able to make himself understood and he understood others. Resident #1 was independent for mobility, transferred independently, used no mobility device and was able to dress independently. Resident #1 currently used tobacco and was coded as receiving oxygen therapy. The record indicated Resident #1 was discharged to the hospital on 10/23/25 for intractable abdominal pain. Resident #1 was readmitted to the facility on 10/26/25. Admission/Readmission Screening for smoking dated 10/26/25 resident was a smoker and on O2 via nasal cannula. A Safe Smoking Assessment dated 10/26/25 completed by the Director of Nursing (DON) revealed Resident #1 currently smoked and had no smoking related incidents. The screen revealed Resident #1 could not verbalize or demonstrate understanding of the facility's smoking policy, or times and place to smoke. The screen revealed Resident #1 was on supplemental oxygen. Resident #1 required supervision while smoking. An interview was conducted with the DON on 11/13/25 at 12:17 PM. The DON stated she began working at the facility on 9/30/25. The DON stated she was not aware of Resident #1 having any smoking related incidents when she completed the 10/26/25 smoking assessment. The DON stated she had observed Resident #1 on multiple occasions walking around outside in front of the building with his oxygen tank. The DON denied seeing the resident smoking with oxygen. The DON reported no staff had reported that Resident #1 was non-compliant with the smoking policies and/or smoked with his oxygen on. Resident #1's medical record revealed an active physician order dated 10/27/25 for continuous oxygen therapy at 3 liters per minute via nasal cannula every shift every day. Resident #1's medical record revealed a physician order dated 10/27/25 for Nicotine Transdermal Patch 24 hour- Apply 1 patch transdermally (the administration of a medication by absorption through the skin) one time a day for Smoking Cessation and remove per schedule.	F0689		

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F0689 SS = SQC-J	Continued from page 14 During an interview with Confidential Source #1 on 11/13/25 at 6:44 PM revealed they (Confidential Source #1) saw Resident #1 smoking outside in an undesignated smoking area with his oxygen in use via nasal cannula on multiple occasions and as recently as on 11/6/25 (unable to recall other specific dates). Confidential Source #1 stated the oxygen tank was removed when Resident #1 was discovered smoking. Confidential Source #1 stated they notified the Administrator on each occasion with the most recent incident being on 11/6/25 that Resident #1 was outside smoking in an undesignated smoking area with oxygen in use via nasal cannula Confidential Source #1 stated the Administrator did not respond when it was reported that Resident #1 was outside smoking with his oxygen in use via nasal cannula. Confidential Source #1 stated they were not aware of any interventions that were implemented to prevent Resident #1 from smoking with oxygen or to monitor the resident. Confidential Source #1 stated they were not aware Resident #1 was a supervised smoker. Confidential Source #1 stated there was supposed to be a list of supervised and unsupervised smokers at the nurses' station. Confidential Source #1 stated they had not seen the smoking list. Confidential Source #1 did not want his/her identity known out of fear of retaliation. During an interview with Resident #1 on 11/12/25 at 12:38 PM, Resident #1 reported about three days ago (11/10/25) he was outside walking with his portable oxygen tank that he was rolling in his oxygen tank carrier cart. Resident #1 stated he walked around the building to the back door to smoke. He indicated another resident (Resident #2) was sitting there as well. Resident #1 revealed he was utilizing his oxygen via nasal cannula. Resident #1 stated when he lit the cigarette on 11/10/25 the cigarette "flamed up". Resident #1 reported he dropped the cigarette and the oxygen tubing cannula on the ground. He stated he stomped the flame out from the cigarette with his foot. Resident #1 indicated when he looked down at the ground, he noticed the oxygen tubing cannula was on the ground with sparks coming from the cannula. Resident #1 stated he stomped on the cannula tubing to put out the flame. Resident #1 stated he did not recall whether the oxygen cannula and tubing were burned or melted. Resident #1 reported that Dietary Aide #1 had come out of the building and made him aware that his shirt was on fire. Resident #1 stated when he saw the flames on the center chest area of his shirt, he immediately took the shirt off. Resident #1 reported when he came inside the facility, the nurse looked at him and called the ambulance. Resident #1 denied that he had any pain. He	F0689		

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F0689 SS = SQC-J	Continued from page 15 stated he went to the hospital where he was treated for burns to his forehead, mustache and side of his mouth. Resident #1 stated he had gotten the cigarette from a visitor and lit the cigarette from a lit cigarette butt on the ground. Resident #1 stated he was not supposed to have the oxygen tank outside with him while he was smoking. Resident #1 verbalized his knowledge that smoking with oxygen could cause a fire. He reported that staff had educated him on the dangers of what could happen if he smoked with oxygen a few times prior to 11/10/25. Resident #1 stated he knew he was supposed to smoke in the designated smoking area where staff could monitor him while he was smoking. Resident #1 stated the facility had scheduled smoking times, but he snuck outside after 5:00 PM on 11/10/25. Resident #1 stated he had gone out to smoke several times prior to 11/10/25 without staff. Resident #1 indicated he sometimes forgot to take his oxygen off when he went out to smoke. He revealed he smoked while his oxygen was flowing via nasal cannula prior to 11/10/25. During an interview with Dietary Aide #1 on 11/13/25 at 2:21PM, she stated it was time for her to end her shift on 11/10/25 at approximately 7:45 PM when she observed Resident #1 and Resident #2 in the employee parking lot outside of the backdoor of the facility. Dietary Aide #1 stated the backdoor was kept locked and there was an access code. Dietary Aide #1 stated Resident #1 was smoking with his oxygen cannula in his nose when she got outside and Resident #2 was sitting in his wheelchair smoking. Dietary Aide #1 stated she looked at Resident #1 and saw the center of his shirt was on fire. Dietary Aide #1 stated she was shocked and afraid of what could happen. Dietary Aide #1 stated she immediately notified the resident that his shirt was on fire and prompted Resident #1 to put the fire out. Dietary Aide #1 stated Resident #1 removed his shirt and put the fire out. Dietary Aide #1 stated she could not remember if she told Resident #1 to put the cigarette out. Dietary Aide #1 stated there was no fire extinguisher or fire blanket in the location to put the fire out. She reported there was only a red fireproof receptacle by the back door. Dietary Aide #1 stated within seconds of making sure the fire was out, she went immediately inside and asked for help from Medication Aide (MA) #1 and Nurse #2. The Dietary Aide stated as soon as she notified Medication Aide #1 and Nurse #2, they immediately rushed to the resident and tried to get Resident #1 to come inside the building. An observation was conducted of the employee parking lot by the back door exit on 11/13/25 at 12:11 PM. There were no windows near the door to allow visibility from the interior of the building. The back door had a	F0689		

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F0689 SS = SQC-J	Continued from page 16 keypad. The employee parking lot was accessible to all by walking around the outside of the building to get to the area. There was a red fireproof receptacle sitting on the ground to the left of the back door and a couple of chairs by the exit. There was no fire extinguisher or fire blanket at this location. An interview was conducted with Resident #2 on 11/13/25 at 12:02 PM. (Resident #2's annual MDS assessment dated 5/26/25 indicated his cognition was intact.) Resident #2 stated he was outside with Resident #1 smoking in the employee parking lot by the back door of the facility the night of 11/10/25. Resident #2 stated he heard this "sizzle" and then saw a flash of fire about the same time Dietary Aide #1 came out the back door. Resident #2 stated he was afraid because he thought Resident #1 was on fire. Resident #2 stated Dietary Aide #1 was very nervous and immediately notified Resident #1 that his shirt was on fire. Resident #2 stated Resident #1 jumped up from the chair he was sitting in. Resident #2 stated Resident #1 snatched the nasal cannula from his nose and pulled his shirt over his head, threw it on the ground and began stomping on it to put the fire out. Resident #2 stated Dietary Aide #1 made sure the fire was out and then she ran back into the building to get help. Resident #2 stated Resident #1 put his shirt back on, sat back in the chair at the back door and was laughing about the incident. An interview was conducted with MA #1 on 11/13/25 at 11:13 AM. MA #1 stated she was working on the unit on the night of 11/10/25 when Resident #1 received a burn from smoking with his oxygen on. MA #1 stated Dietary Aide #1 ran in the building and was out of breath, appeared alarmed and shouted she had walked out the back and saw Resident #1's shirt on fire. MA #1 stated she went and notified Nurse #2 and went running out the back door. MA #1 stated when she got outside Resident #1 was sitting in the chair beside the door with his shirt lifted. MA #1 stated she did not see any fire when she got to Resident #1 and couldn't recall if she saw any marks on him at that time. MA #1 further stated Resident #1's oxygen tank was sitting in the wheeled tank holder beside the chair Resident #1 was sitting in. MA #1 stated she could not recall if she saw a cigarette in the resident's hand while he was sitting in the chair. MA #1 stated Resident #2 was sitting in his wheelchair in the employee parking lot by the back door. She could not recall if she had seen a cigarette in Resident #2's hand. MA#1 stated she assisted Resident #1 back to his room so the nurse could assess him because he refused to go to the nurse's station. MA #1stated there was a list of supervised and	F0689		

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F0689 SS = SQC-J	Continued from page 17 unsupervised smokers kept at the nurse's station. MA #1 stated Resident #1 was listed as a supervised smoker on the smoking list. MA #1 stated Resident #1 reported he had gone out the front door and walked around the building to the employee parking lot by the back door. MA #1 did not know where Resident #1 had gotten the cigarette from or how he lit it. MA #1 stated Resident #1 was not supposed to be out back smoking. During an interview with Nurse #2 on 11/13/25 at 10:31 AM, she stated she was the nurse on duty on the night of 11/10/25 when Resident #1 received a burn from smoking a cigarette with his oxygen on. Nurse #2 stated MA #1 came and notified her that Resident #1 was smoking and had caught fire. Nurse #2 stated she and MA #1 ran out to where Resident #1 was located and he was sitting in a chair at the back door with another lit cigarette in his hand and Resident #2 was present. Nurse #2 stated she told the resident to put the cigarette out. Nurse #2 stated Resident #1 was not wearing the nasal cannula when she approached him outside the back door. Nurse #2 did not recall where the nasal cannula was at that time. Nurse #2 stated she believed Resident #2 had his shirt on when she went to look at him, but she did not recall seeing a burnt area on his shirt. Nurse #2 stated once the cigarette was put out, she asked MA #1 to assist Resident #1 to the nurse's station so she could assess him in the light. Nurse #2 stated she went looking for Resident #1 because about 10 minutes had passed and he had not made it to the desk. Nurse #2 stated she found Resident #1 in the hallway bathroom located beside his room trying to wash his face. Nurse #2 stated she observed Resident #1's mustache was burnt, the smile lines to both sides of his mouth looked red and fleshy, and his forehead had a burn mark. Nurse #2 stated Resident #1 refused at first to go out to the hospital to have the burns looked at. Nurse #2 stated he became aggressive and yelled at her to get out of the bathroom. Nurse #2 stated she called the Director of Nursing about the incident and was told to notify the on-call physician for an order to send resident out to the hospital for evaluation and treatment. Nurse #2 stated she called Emergency Medical Services (EMS) and Resident #1 continued to refuse to be transported to the hospital. Nurse #2 stated when EMS got to the facility, they were able to speak to Resident #1 about the importance of being checked out and he was transferred to the local hospital. During an interview with Nursing Assistant (NA) #1 on 11/14/25 at 2:01 PM, he stated he was the NA that was assigned to Resident #1 on the night of 11/10/25 when	F0689		

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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
F0689 SS = SQC-J	Continued from page 18 Resident #1 received a burn from smoking a cigarette with his oxygen on. NA #1 stated Resident #1 was independent with activities of daily living. NA #1 stated Resident #1 was ambulatory and walked around the facility independently. NA #1 stated Resident #1 was a smoker, but he was not aware Resident #1 required supervision. NA #1 confirmed Resident #1 wore continuous oxygen via nasal cannula and ambulated around with a portable oxygen tank in a wheeled holder. NA #1 stated when he was assigned to provide supervision to take the residents outside to smoke he would remind Resident #1 not to wear his oxygen outside. NA #1 stated there was a list at the nurse's station of supervised and unsupervised smokers but he did not recall Resident #1 being a supervised smoker. NA #1 further stated Resident #1 was usually in the front of the building when he saw the resident smoking which was not a designated smoking area. NA #1 stated he would redirect the residents to the designated smoking area if he saw any resident smoking in an undesignated area. NA #1 stated he would occasionally see residents at the back door with the employees (dietary staff and housekeeping staff) and he would immediately correct the residents and redirect them to go to the designated smoking area. NA #1 reported that on the night of 11/10/25 when Resident #1 received a burn from smoking with his oxygen on he was called outside by Dietary Aide #1. NA #1 stated when he got outside he observed Resident #1's mustache was singed. He did not notice if Resident #1's shirt was burnt. NA #1 reported Resident #1 was laughing about the incident and thought the situation was funny. NA #1 stated he did not recall seeing Resident #2 in the back on 11/10/25. The Emergency Department Discharge Summary dated 11/11/25 revealed Resident #1 was seen for flash burn. Resident #1 was on 3 liters of oxygen for end stage COPD. Resident #1 was smoking a cigarette while he had oxygen on and experienced a flash burn. He was unable to describe the events. Resident #1 was not in pain and did not have any trouble breathing. Resident #1 had singed nose hair in both nares (nostrils) and a burn to the upper left lip with dermis exposed. A Nursing Progress Note completed by Nurse #3 dated 11/11/25 revealed Resident #1 returned to the facility from the emergency department at 2:03 A.M. via transport. Resident #1 was treated for burns. Resident #1 was assisted to bed and denied any pain at that time. During an interview on 11/12/25 at 1:04 PM with Medication Aide (MA) #2 who was assigned to the	F0689		

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F0689 SS = SQC-J	Continued from page 19 resident, she stated Resident #1 was a supervised smoker and he required staff assistance to go out to smoke. MA #2 stated most of the time when she observed Resident #1, he would have the oxygen tank sitting by the door away from him when he was smoking. MA #2 was unable to give an estimate of the distance the oxygen tank was from the resident when he was smoking. MA #2 stated Resident #2's oxygen tank should be left inside the building when he went out to smoke. MA #2 stated she had never witnessed Resident #1 smoking with his oxygen tank present. MA #2 stated that staff who were assigned to go outside to supervise smokers were responsible for issuing the smoking materials and making sure the smokers turned the smoking materials back in. During an interview with the Director of Nursing on 11/13/25 at 12:17 PM, the DON stated she received a call from Nurse #2 on 11/10/25 to let her know Resident #1 received a burn from smoking a cigarette with his oxygen on. The DON stated the nurse reported Resident #1 was breathing with his accessory muscles (use of muscles other than primary muscles to help with breathing) and had some burns on his face. The DON stated she instructed Nurse #2 to call the on-call provider. The DON stated Nurse #2 called her back after calling the provider and she told the nurse to get EMS on the way so that they could evaluate the resident. The DON stated she had never witnessed Resident #1 smoking with his oxygen tank. She reported that Resident #1 indicated he had gotten the cigarette from a visitor and lit it from a cigarette butt. The DON stated Resident #1 was a supervised smoker and an intervention was added to remove his oxygen prior to Resident #1 going out to smoke. The DON was unable to explain why the intervention to remove Resident #1's oxygen was added to his care plan on 10/21/25. The DON spoke about the smoking policy and issues the facility was having with residents who smoked. The DON explained that facility had been having a lot of issues with unsupervised residents just wanting to go smoke in any area. The DON stated the smoking policy was being reviewed and education was being conducted with residents about smoking in the designated smoking area. The DON stated the facility did have a designated area for smoking. The DON stated she felt that there were several areas of breakdown in the smoking process. The DON reported that staff had given the residents the code to the exit doors, visitors would bring cigarettes to residents and staff were unaware, and some unsupervised smoking residents had refused to turn in their smoking materials. The DON stated there was a list of supervised and unsupervised residents that	F0689		

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F0689 SS = SQC-J	Continued from page 20 smoke at the nurse's station. The DON stated the staff were to refer to the list to verify the residents' smoking status. The DON stated she was not aware there were staff who did not know Resident #1 required supervision when smoking. The DON stated smoking materials were stored at the nurses station and the person assigned to supervise the smokers was responsible for making sure smoking materials were returned. During an interview with the Medical Director on 11/18/25 at 10:35 AM, she stated she was made aware on 11/10/25 that Resident #1 received a burn from smoking a cigarette with his oxygen on. The Medical Director stated she was surprised because she had seen Resident #1 the week prior and he had expressed his desire to stop smoking because he had a medical procedure coming up. The Medical Director stated that she ordered nicotine patches for Resident #1 on 10/27/25. The Medical Director stated she was not aware Resident #1 had smoked with oxygen previously. The Medical Director expressed her concern for Resident #1 smoking with oxygen since it was extremely flammable. She also expressed concern that Resident #1 not only put himself in danger but the entire building. The Medical Director stated when she visited Resident #1 after the incident on 11/12/25 he reported someone else had given him the cigarette and he had lit the cigarette using a lit cigarette butt. The Medical Director further stated she did not feel that Resident #1 understood the gravity of the situation. An interview was conducted with the Administrator on 11/18/25 at 3:30 PM. The Administrator stated Resident #1 should not have been smoking with oxygen on unsupervised and he should have been in the designated smoking area. The Administrator stated Resident #1 should not have been able to obtain smoking material from a visitor. The Administrator stated Resident #1 had not smoked with his oxygen on before to her knowledge. The Administrator denied being told about Resident #1 smoking with oxygen present and in use prior to 11/10/25. The Administrator stated she was not aware that staff did know Resident #1 was a supervised smoker. The Administrator stated there had been smoking list at the nurses' stations since she arrived at the facility at the end of July 2025. The Administrator stated smoking materials were stored at the nurses' station and the person assigned to supervise the smokers was responsible for making sure smoking materials were returned.	F0689		

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F0689 SS = SQC-J	Continued from page 21 The Administrator was notified of immediate jeopardy on 11/13/25 at 12:07PM. The facility provided the following immediate jeopardy removal plan: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: The facility failed to ensure accurate assessment, supervision, and care planning for a resident who smokes while using oxygen. The facility staff failed to effectively intervene with observations of the resident smoking with oxygen. On 11/10/25, resident #1 was in the parking lot with his oxygen tank in use and smoking. Resident #1 was observed by dietary aide #1 with his shirt on fire. Due to the area not being the designated smoking area, there were limited items to help extinguish the fire such as a fire blanket. Dietary aide #1 let Resident #1 know about his shirt, and resident #1 immediately pulled his shirt off to extinguish the fire. After the fire and cigarette were extinguished, the Dietary aide then went inside to request help from a nurse. Resident #1 was assessed by the assigned nurse. The provider was notified. A new order was obtained to send resident #1 to the hospital. Resident #1 was transported to the hospital where he was diagnosed and treated for second degree flash burn to his face which burned his upper lip and singed the nose hair in both nostrils. On 11/11/2025, the Administrator informed the Director of Nursing to place Resident #1 on 1:1 supervision when resident #1 returned from the hospital. Resident returned from the hospital in the early morning of 11/11/2025. The Director of Nursing informed the Scheduler to assign 1:1 and explained the importance of monitoring resident #1. The Director of Nursing and/or Scheduler explained to the staff assigned 1:1 the importance of monitoring resident #1 and why. Resident # 1 will be monitored indefinitely. The code to the door leading to the area resident was found smoking in was changed by the Maintenance Director. Only the Administrator and the Maintenance Director have the code. (Our fire exit doors have kill switches and the push for 15 seconds to release in case of an emergency. The staff will be given the code in case of an emergency.)	F0689		

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F0689 SS = SQC-J	Continued from page 22 On 11/11/2025 an audit of residents that use oxygen and residents that smoke was completed by the Nurse Consultant. Interviews with alert and oriented residents and current staff were completed on 11/13/25 by the Director of Nursing, Unit Manager, Minimum Data Set Nurse and/or Treatment nurse. The audit was conducted to ensure all identified residents have had no history of noncompliance with wearing oxygen while smoking as validated with interviews held with current staff in the facility and alert and oriented residents. Resident #1 is the only resident that requires oxygen and wants to smoke. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: On 11/13/25, an in-service was completed by the Director of Nursing and administrator regarding smoking compliance for current staff to include agency staff. The in-service emphasized smoking guidelines to include smoking only in the designated smoking area, removal of oxygen prior to going outside in general and/or to smoke. Smoking is allowed only in the designated area and immediately reporting any noncompliance with the smoking policy to the assigned nurse. The nurse will ensure resident is safe, placed on 1:1 monitoring, and notify the Director of Nursing/Administrator. After 11/13/25, any staff, including agency staff that have not received the in-service, will do so prior to the next scheduled shift. All newly hired staff will receive the in-service during orientation by the Director of Nursing or Administrator. The Director of Nursing, Scheduler, and/or Unit Manager will ensure staff are educated prior to their next shift. On 11/13/25, current residents who smoke were educated by the Administrator and Director of Nursing regarding smoking safety with emphasis on smoking only in the designated area, compliance with removing oxygen prior going outside to smoke if applicable, not sharing smoking materials to include cigarettes or vapes with any other residents, and nursing will ensure smoking materials are secured on the med cart. Smoking materials will only be removed and given to staff assigned to take residents out to smoke during	F0689		

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F0689 SS = SQC-J	Continued from page 23 designated smoke times. The assigned staff member responsible for taking the residents out to smoke will give all smoking materials back to the nurse to lock up. Any independent smoking resident observed or reported to the Administrator or Director of Nursing not adhering to smoking safety education will be required to be supervised while smoking. Residents receiving education verbalized understanding. On 11/13/25, the administrative staff assisted with posting laminated signage at the smoking exit door as reminders for all residents and staff to remove residents' oxygen prior to going out to smoke in the designated smoking area. On 11/13/25, signage stating “no oxygen allowed-designated smoking area” was also posted at all four corners of the designated smoking area by the unit manager as an additional reminder to residents and staff to remove oxygen. Corporate is in the process of ordering signs that are more durable. Once delivered, the facility Maintenance Director will replace old signs with more durable signs. On 11/13/2025, the Director of Nursing informed the Unit manager to create binders with lists of supervised and unsupervised smokers and placed the binders at both nurses stations and at the front desk. On 11/13/25, the Director of Nursing and Unit Manager educated nursing staff regarding any staff member assigned to take residents out to smoke must check the binder prior to taking the resident to smoke. On 11/13/2025, the Director of Nursing and the Unit Manager were educated by the Administrator regarding their responsibility for ensuring that the binder is kept updated. On 11/11/25, education for all current staff to include agency staff was initiated by the Director of Nursing and regional nurse consultant regarding supervised smokers needing staff supervision during smoking periods. Education included reminders that oxygen cannot be in the designated smoking areas and that oxygen use while smoking can result in serious harm, the location of the fire blanket, proper smoking receptacles, and the location of supervised/unsupervised smoking binders to identify current smoking residents. Nursing will ensure smoking materials are secured on the med cart. Smoking materials will only be removed and given to staff assigned to take residents out to smoke during designated smoke times. The assigned staff member responsible for taking the residents out to smoke will	F0689		

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F0689 SS = SQC-J	Continued from page 24 give all smoking materials back to the nurse to lock up. On 11/11/2025, The Administrator educated and assigned the Receptionist to give all visitors information regarding the following: 1. Not to give any residents cigarettes or smoking materials. 2. Residents must be kept safe by adhering to our smoking times and designated smoking areas. 3. Violating this will result in restricted visitation for the visitor. Visitors are to sign a signature sheet to acknowledge their understanding. Our current process is prior to entering the code to the door to let the resident out to smoke; oxygen must be removed from resident and/or resident wheelchair. The oxygen will be stored in an oxygen holder and replaced once resident comes back inside of the building. If a resident refuses oxygen removal they will have a staff member with them when they exit to ensure no smoking with oxygen in place. Alleged date of Immediate Jeopardy Removal: 11/14/25 The facility's immediate jeopardy removal plan was validated onsite on 11/19/25. Observations were conducted of staff providing 1:1 monitoring of Resident #1. Audits of all residents that used oxygen were conducted and Resident #1 was the only resident that used oxygen and smoked. Review of in-service education regarding smoking compliance, and smoking guidelines to include smoking only in designated smoking areas and the removal of oxygen prior to going outside to smoke. The in-service also included not sharing smoking materials and ensuring smoking materials were secured on the medication cart was reviewed and signed by all staff. Review of signed education materials for residents revealed 6 of 7 unsupervised smokers signed the education, 1 unsupervised smoker was educated but refused to sign the education, and all 9 supervised smokers signed the education. Follow up with the resident that refused to sign the education revealed he was able to verbalize understanding. Observations were conducted of "No Smoking" signage in unauthorized locations and signage that identified the designated smoking area. Signs were observed by the side door as a reminder for residents and staff to remove residents' oxygen prior to the resident going out to smoke.	F0689		

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F0689 SS = SQC-J	Continued from page 25 Observation was conducted of the Smoker binders at nurses' station, and the Unit Manager /Director of Nursing was responsible for making sure the binder was updated. Interviews were conducted with the staff who confirmed they received education regarding the smokers' binders, education on smoking in designated areas and the staff providing supervision was responsible for making sure the residents returned their smoking materials. The facility's immediate jeopardy removal date of 11/14/25 was validated. 2a. Resident #2 was admitted to the facility on 8/3/21. The care plan initiated on 8/4/21 revealed a focus that Resident #2 wished to smoke. The interventions included to educate Resident #2 and family regarding the facility's smoking policy, designated smoking area and storage of smoking materials; orient resident to the facility's designated smoking area; and monitor safety during smoking. The annual Minimum Data Set (MDS) assessment dated 5/26/25 revealed Resident #2 was cognitively intact and used a manual wheelchair for mobility. Resident #2 was independent with transfers and used tobacco. A Safe Smoking Screen Assessment dated 10/29/25 completed by the MDS Coordinator revealed Resident #2 currently smoked and was able to smoke independently (without supervision). An observation was conducted of Resident #2 on 11/12/25 at 2:45 PM. The resident was sitting in his wheelchair smoking on the left side of the building (if facing the front door from the outside) approximately 100 feet away from the designated smoking area. There were no other residents or staff present. This area contained no fire safety implements such as ash trays, smoking receptacles, fire blankets, fire extinguisher and fireproof waste bins. During an interview with Resident #2 on 11/13/25 at 12:02 PM, he stated the unsupervised smokers went out to smoke anywhere. He indicated he was an unsupervised smoker. Resident #2 stated the previous Administrator had talked with him about smoking in the designated smoking area at scheduled times. Resident #2 stated the facility did not like for residents to go to employee parking lot outside of the backdoor of the facility to smoke. Resident #2 stated he usually smoked by the back door. Resident #2 stated he kept his own cigarettes and lighter because the facility had issues with staff not wanting to take residents out to smoke at the correct times. Resident #2 stated the facility wanted him to	F0689		

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F0689 SS = SQC-J	Continued from page 26 turn in his cigarettes and lighter to the nurse, but he refused. An observation was conducted during the interview with Resident #2 revealing that he was in possession of a cigarette pack containing 3 cigarettes and a lighter located underneath the pillow of his bed. 2b. Resident # 5 was admitted to the facility on 12/20/23 and readmitted on 9/10/25. The care plan initiated on 3/14/25 revealed Resident #5 was an unsupervised smoker. The interventions included Resident #5 will be oriented to the facility's designated smoking area. A Safe Smoking Screen dated 9/10/25 revealed Resident #5 currently smoked and was able to smoke independently (without supervision). The admission MDS assessment dated 9/16/25 revealed Resident #5 was cognitively intact and used tobacco. Resident #5 was independent for transfers and used a manual wheelchair for mobility. An observation was conducted of Resident #5 on 11/12/25 at 1:32 PM. Resident #5 was outside of the facility on the left side of the building (if facing the front door from the outside) approximately 100 feet from the designated smoking area smoking a cigarette. Resident #5 was not in the designated smoking area. There were no other residents with Resident #5. This area contained no fire safety implements such as ash trays, smoking receptacles, fire blankets, fire extinguisher and fireproof waste bins. An observation was conducted of Resident #5 on 11/12/25 at 5:15 PM. Resident #5 was sitting in the wheelchair outside of the facility on the left side of the building approximately 100 feet from the designated smoking area smoking a cigarette. Resident #5 was not in the designated smoking area. There were no other residents with Resident #5. An interview was conducted with Resident #5 on 11/12/25 at 5:22 PM. Resident #5 stated he smoked in the designated smoking area. He indicated he believed the location he was observed smoking on 11/12/25 at 1:32 PM and 5:15 PM was the designated smoking area. Resident #5 stated he kept his cigarettes and lighter on his person because he did not require supervision. He indicated he believed he had the right to keep his cigarettes and lighter. 2c. Resident #4 was admitted to the facility on 9/28/25.	F0689		

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F0689 SS = SQC-J	Continued from page 27 The Safe Smoking screen dated 9/28/25 revealed Resident #4 was safe to smoke independently (unsupervised). The admission Minimum Data Set (MDS) dated 10/4/25 revealed Resident #4 was cognitively intact and used tobacco. Resident #4 transferred independently and ambulated independently. As of 11/12/25, Resident #4 had no care plan related to smoking. An observation was conducted on 11/13/2025 at 3:35 PM. Resident #4 was observed outside of the facility on the left side of the building (if facing the front door from the outside) approximately 100 feet away from the designated smoking area. This area contained no fire safety implements such as ash trays, smoking receptacles, fire blankets, fire extinguisher and fireproof waste bins. 2d. Resident #3 was admitted to the facility on 1/13/25. The care plan initiated on 1/13/25 and revised on 3/14/25 revealed Resident #3 had been non-compliant with smoking times, policies and area. Resident #3 was to be a supervised smoker with cigarettes and lighters kept at the nurse's station. The goal was for Resident #3 to smoke in designated area through next review. The interventions included instructing the resident about the facility policy on smoking: location, times, safety; and for the resident not to keep his cigarettes and lighter on his person. The care plan initiated on 7/21/25 revealed Resident #3 was a supervised smoker and had behaviors related to smoking that included attempting to burn staff member with a cigarette, refusal to follow smoking policies, and refusal to give his cigarettes and lighter to staff. The interventions included notifying the charge nurse immediately if it was suspected resident had violated the facility's smoking policy and the resident's smoking supplies were to be stored on the medication cart or medication supply room. The Safe Smoking Screen Assessment dated 9/30/25 revealed Resident #3 currently smoked and required supervision for smoking. The screen further revealed Resident #3 had a history of smoking related incidents (refusing to follow smoking policies and refusing to give cigarettes and lighter to staff) and smoking in non-smoking areas.	F0689		

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F0689 SS = SQC-J	Continued from page 28 The quarterly MDS Assessment dated 10/9/25 revealed Resident #3 was cognitively intact. Resident #3 had no impairment to upper extremities and impairment to both sides of his lower extremities. Resident #3 used a manual wheelchair for mobility. Resident had no behaviors or rejection of care during the lookback period. An observation was conducted on 11/13/2025 at 8:56 AM. Resident #3 was observed in his wheelchair smoking a cigarette outside the front entrance of the facility. This was not a designated smoking area and the resident was not being supervised by staff. The front door had a no smoking sign visible from the outside of the building, but a smoking receptacle was present. During an interview with Resident #3 on 11/13/25 at 8:59 AM, the resident stated he smoked at the front door area from “time to time”. Resident #3 stated the facility had scheduled smoking times and he went outside with staff at those times to smoke in the designated smoking area. Resident #3 stated he was unable to propel himself outside to the smoking area and staff would assist him. Resident #3 was unable to give a description of the staff that assisted him outside to the front porch but stated he told the staff he just wanted to go out to sit on the porch. Resident #3 stated he was told he was supposed to be supervised. Resident #3 stated he had a pack of cigarettes and lighter which he kept on his person. An interview conducted with Medication Aide (MA) #1 on 11/13/25 at 11:13 AM revealed Resident #3 required supervision while smoking. MA #1 stated Resident #3 was supposed to get his smoking materials from the staff at the designated smoking times. She was unaware that Resident #3 had been outside on the front porch smoking. During an interview with Confidential Source #2 on 11/14/25 at 12:11 PM it was stated that residents did not have a designated smoking area enforced prior to a smoking incident on 11/10/25 in which Resident #1 sustained a flash burn. Confidential Source #2 stated residents went out to smoke at any time and there was no scheduled time. Confidential Source #2 stated most residents smoked outside of the facility to the left side of the front entrance (if facing the building from the front) by the door close to the rehabilitation department which was approximately 100 feet in front of the designated smoking area. Confidential Source #2 also reported that some residents smoked on the front porch rather than in the designated smoking area. Confidential Source #2 stated there was no formal	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345344	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS = SQC-J	Continued from page 29 process in place that was implemented to supervise residents while smoking. Confidential Source #2 reported that the Director of Nursing (DON) and Administrator had been notified by Confidential Source #2 on multiple occasions that residents were smoking in undesignated areas and there was nothing implemented to address the issue. Confidential Source #2 stated they did not want the facility to know their identity due to fear of being fired. During an interview with Nursing Assistant (NA) #1 on 11/14/25 at 2:01 PM he stated he had observed residents smoking in front of the building which was not a designated smoking area on multiple occasions. NA #1 stated he would redirect the residents to the designated smoking area if he saw any resident smoking in an undesignated area. NA #1 stated he would occasionally see residents at the back door of the facility with the employees (dietary staff and housekeeping staff) and he would immediately correct the residents and redirect them to go to the designated smoking area. An interview was conducted with the Administrator on 11/18/25 at 3:30 PM. The Administrator stated residents were screened upon admission to determine which residents were smokers. She reported that based on the screenings, residents who were smokers were assessed for safe smoking and educated on the location of the designated smoking area and scheduled smoke times. She indicated all residents' smoking materials, whether the resident was a supervised or unsupervised smoker, were to be kept by the nurse. The Administrator stated when she began working at the facility in August of 2025, residents were smoking in undesignated areas and there were no scheduled times for smoking. She reported she began educating residents on the smoking policy and reoriented the residents to the location of the designated smoking area. The Administrator stated scheduled smoking times were implemented. She indicated the designated smoking area was located on the side of the building and assigned staff took residents who required supervision to smoke out of the side door of the facility to access the designated smoking area. The Administrator stated staff were to report to her (the Administrator) or the DON when residents were not following the smoking policy and/or smoking in the designated smoking area. She reported a smoking list was located at the nurses' station so that assigned staff knew which residents required supervision and which residents could smoke without supervision. The Administrator stated that at the designated smoking	F0689		

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F0689 SS = SQC-J	Continued from page 30 times the residents that wished to smoke would meet the assigned staff at the nurses' station. She indicated that the assigned staff, designated on the daily staffing assignment sheet, were to review the list of residents that smoked. The assigned staff member would then retrieve the smoking materials from the lockbox for the residents that wanted to smoke and assist those residents to the designated smoking area. The Administrator stated the assigned staff passed out smoking materials to unsupervised smokers and the assigned staff were responsible for making sure the unsupervised smokers returned their smoking materials.	F0689		