

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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 Camellia Gardens Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 280 South Beckford Drive Henderson, NC 27536	
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)		
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 [DATE].The Emergency Department Discharge summary dated [DATE] 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.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.</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE].The Safe Smoking screen dated 9/28/25 revealed Resident #4 was safe to smoke independently (unsupervised).The admission Minimum Data Set (MDS) dated [DATE] 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 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.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 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 [DATE]. His diagnoses included chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD). Resident #1's Smoking Screening's dated</p>		