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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335657	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Campbell Hall Rehabilitation Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 23 Kiernan Rd Campbell Hall, NY 10916	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interviews during an abbreviated survey (NY00335594), the facility did not ensure the Minimum Data Set (an assessment tool) accurately reflected the resident's status for 1 (Resident#1) out of 3 residents reviewed. Specifically, Resident #1's Quarterly Minimum Data Set, dated dated dated [DATE] had no documented evidence of the resident's rejection of care, having a pressure ulcer, and complaints of occasional mild pain. Findings include: Resident #1 had diagnoses that included non-pressure ulcer other part of the right foot with fat layer exposed, cellulitis, other chronic pain, lymphedema, depression, opioid dependence in remission, muscle weakness and osteomyelitis. Review of the Quarterly Minimum Data Set, dated dated dated [DATE] documented in Section E0800 (titled Rejection of care presence and frequency) revealed that the resident did not exhibit the behavior of rejection of care that is necessary to achieve goals for health and wellbeing, such as assistance with activities of daily living. Staff assessment for pain Sections J0800 and J0850 revealed that the resident had no documented indicators of pain in the last 5 days. Section M0210 revealed that the resident did not have any unhealed pressure ulcers and Section M300 had no documented skin conditions. A behavior care plan dated 8/9/2023 and last updated 3/7/2024 documented Resident #1 does not allow staff to change their adult depends, refuses daily showers, and refuses to have their leg and foot assessed and cleaned. The Social Worker and staff will continue to educate and encourage, to assist the staff with their cares by being willing to care for themself. A risk for pain care plan dated 7/31/2020 and last revised 3/7/2024 documented the resident is at risk for alteration in comfort due to pain, related to chronic pain and lymphedema diagnoses. A pain assessment dated [DATE] documented, Resident #1 had mild occasional pain. (continued on next page)

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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/2024 at 10:50 AM, the Minimum Data Set Coordinator stated they are responsible for updating the Minimum Data Sets and that the Sigma care (an electronic medical system) notifies them when someone is due for the Minimum Data Set, then they schedule it. The Minimum Data Set coordinator stated once the assessment is scheduled, the corresponding sections will be ready to be completed by the appropriate staff. The Minimum Data Set coordinator stated Sections C, D, E and Q are completed by Social Services; Section K is the dietary section and is completed by the dietician. The Minimum Data Set coordinator stated during morning report any issues with residents are discussed and they also use that information during the 7-day look back to complete the Minimum Data Set. During an interview on 3/29/2024 at 12:20 PM, the Social Service Director stated their responsibility on the Minimum Data Set is the resident assessment, for which they conduct an interview and complete the behavior/mood assessment. If the resident provides them with this information, they will review the progress notes and interview staff to obtain the details. The Social Service Director stated Resident #1 told them they were not allowing the staff to change their bandages. The Social Service Director stated they update the care plans along with the assessments and they try to review the care plans within 90 days. If there is no longer an issue in a certain area for the resident, the care plan will be discontinued. If the resident meets a goal, the care plan is resolved.This process is new to them and they are trying to get better at it. During a follow up interview on 4/18/2024 at 10:10 AM, the Minimum Data Set coordinator stated they only review the Minimum Data Set sections that they complete, and they review the other sections of the Minimum Data Set to make sure they are completed. They stated there is no safeguard in place to ensure the other sections are completed accurately. All sections of the Minimum Data Set should be accurate as staff members receive training on how to complete the sections. The Minimum Data Set Coordinator stated if the resident does have behaviors, nursing or social work should be entering this in their notes. The Minimum Data Set is coded incorrect based on the information available. The Minimum Data Set Coordinator stated all the staff knew Resident #1 constantly refused cares but if there is no documentation then they cannot code that in the Minimum Data Set. The Minimum Data Set coordinator reviewed Resident #1's record and stated there is a wound care note documenting a refusal on 12/20/2023, and this would support the rejection of care section in the Minimum Data Set. They stated they will review and make this correction to the 12/22/2023 Minimum Data Set now. Further review of Resident #1's record by the Minimum Data Set coordinator revealed documentation on 12/13/2023 of a non-pressure wound Stage 3, and they stated this should have been coded in the Minimum Data Set assessment. The Minimum Data Set coordinator stated this was out of the look back period of 7 days, but it should have been coded as Resident #1 was receiving treatment. They stated the Treatment Administration Record does not reflect the wound treatment clearly so they will go back and review the orders. 10NYCRR 415.11(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49372 Based on record review and interviews conducted during an abbreviated survey (NY0035594), the facility did not ensure comprehensive care plans were reviewed/updated quarterly and as needed in a timely manner. This was evident for 1 (Resident #1) out of 3 residents reviewed for care planning. Specifically, Resident # 1's Care Plans for Pain, Osteomyelitis, Lymphedema, Pressure Ulcer, and Behavior were not updated quarterly and after a comprehensive assessment. Findings include: The facility care plan policy last reviewed on 3/4/24 documented comprehensive care plans (CCP) must be updated quarterly, annually and upon readmission, and with a significant change of condition. Resident #1 had diagnoses that included non-pressure ulcer other part right foot with fat layer exposed, cellulitis, other chronic pain, lymphedema, depression, opioid dependence in remission, muscle weakness and osteomyelitis. Review of the quarterly Minimum Data Set (an assessment tool) dated 12/22/2023 documented a score of 13/15 denoting intact cognition, impairment on both side of upper and lower extremities. Requires set-up assistance for eating and is dependent for toileting, bed mobility and transfers. Resident is always incontinent of bladder and occasionally incontinent of bowel. Resident is at risk for pressure ulcers, pressure reducing device in chair and bed. Application of non-surgical dressing other than to feet and ointments/medications applied other than to feet. Review of a care plan dated 3/30/20 and last updated on 9/11/23 documented that the resident had an Infection, Chronic Osteomyelitis, resident has dx of chronic osteomyelitis, and is currently receiving long-term oral doxycycline. Review of a care plan dated 7/31/20 and last revised 3/7/2024 documented that the resident was at risk for pain and at risk for alteration in comfort due to pain related to chronic pain and lymphedema. Review of a care plan dated 9/6/21 and last revised 8/9/2023 documented that the resident had a behavior of non-compliance with cares and medications, problem resists care for showering and bathing despite education, refuses to get into their bed and will sleep in their wheelchair, refuses to elevate legs secondary to bilateral lower extremity edema, refuses morning medications. The Resident refuses showering despite education and interdisciplinary (IDT) interventions. The Resident prefers only bed baths. The education of benefits of showering as opposed to bed baths. Per their request they will be given bed baths unless they request different. Review of a care plan dated 8/9/2023 and last updated 3/7/2024 documented behaviors, problem, resident does not allow staff to change their adult depends, refuses daily showers, refuses to have their leg and foot assessed and cleaned. The Social Worker and staff will continue to educate and encourage to assist the staff with their cares by being willing to care for themself. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a care plan dated 12/3/23 last updated on 3/7/24 documented, Edema/history of lymphedema- Resident presents with a PMH of edema of Lymphedema, which may cause edema/ increased swelling to arms and legs, placing him at risk for adverse event including compromise to skin, fluid overload and cellulitis. Review of a care plan dated 12/3/23 last updated on 3/7/24 documented, Edema/hx of lymphedema- Resident presents with a PMH of edema of Lymphedema, which may cause edema/ increased swelling to arms and legs, placing him at risk for adverse event including compromise to skin, fluid overload and cellulitis. Review of a care plan dated 7/18/23 last updated on 3/7/24 documented presence of pressure ulcer resident has a skin breakdown as evidenced by (breakdown to both upper thigh/posterior/Bilateral lower extremity). Further review of the behavior care plans revealed there were no interventions documented for the behaviors identified. During an interview on 3/14/2024 at 2:50 pm the Director of Nursing stated the Registered Nurses on the unit are responsible for updating the care plans, they are supposed to be updated on a quarterly basis. Stated prior to having adequate registered nurse staff on the units, due to staffing issues, the registered nurse supervisors were to update the care plans for the residents. During an interview on 3/14/2024 at 3:10 PM Staff #4 (Licensed Practical Nurse unit manager-1st floor) stated the care plans are updated on the unit by both unit managers (Licensed Practical Nurse and Registered Nurse unit manager). Stated the system gives them an alert in red or green, meaning due or overdue. If it does not get done in time the alert will go to the red side meaning, get it done now. During an interview on 3/14/2024 at 3:15 PM Staff #5 (Registered Nurse unit manager-1st floor)-stated the care plans are due quarterly or annually for residents that have been here for some time. Stated for new admissions the care plans are updated within 5 days after their admission. On our dashboard in the system, we get notices that the care plans are due, they are either in red or green, green meaning it is due or red meaning it is overdue. During a follow up interview on 3/14/2024 at 4 pm the Director of Nursing stated the dates shown for the care plans are the only dates they were reviewed. 10NYCRR 415.11(c)(2)(i-iii)