STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335657	A. Building B. Wing	12/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Campbell Hall Rehabilitation Center Inc	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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview conducted during the Recertification, Abbreviated (NY00359302) and Extended Survey from 12/15/24 - 12/22/24, the facility did not ensure residents had a right to make choices regarding aspects of their life for 5 of 6 residents reviewed for smoking. Specifically, the facility did not offer a designated smoking area and did not offer a smoking cessation program prior to and after the facility changed its policy to prohibit smoking for Resident # 6, #9, #29, #41, and #54 who were known smokers at the time of admission. The findings are: The Policy and Procedure titled Smoking revised on 1/21/22 documented the facility aimed to maintain the highest quality of life for each resident who smoked, and smoking was permitted only in designated areas and at scheduled times. The Policy and Procedure titled Smoking created 6/23/22 documented the facility was to maintain the highest quality of life for each resident, and smoking will not be permitted by residents. During observation on 12/15/24 at 1:15 PM patio doors were marked with No Smoking signs. 1. Resident #29 was admitted to the facility on [DATE] with diagnosis including Schizophrenia (serious mental illness) Diabetes and Anxiety. The 10/14/24 Quarterly Minimum Data Set (assessment tool) documented Resident #29 was cognitively intact. There was no documented evidence in Resident #29's electronic medical record that a smoking assessment to identify smoking habits, smoking cessation counseling, nicotine replacement options, and staff training in regards to smoking cessation programs had been offered when the facility changed its policy to prohibit smoking. During an interview on 12/15/2024 at 4:20 PM Resident #29 stated smoking was permitted when they were admitted to the facility, but later they had been made aware, smoking at the facility was no longer allowed. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #41 was admitted to the facility on [DATE] with diagnoses including Paraplegia, (total loss of movements and sensation in the lower body) Borderline Personality Disorder (a mental disorder) and Schizophrenia. The Quarterly Minimum Data Set (assessment tool) dated 4/19/24, documented Resident #41 was cognitively intact. There was no documented evidence in Resident #41's electronic medical record that smoking cessation counseling, nicotine replacement options, and staff training in regards to smoking cessation programs had been offered when the facility changed its policy to prohibit smoking. During an interview on 12/15/24 at 1:11 PM Resident # 41 stated they were admitted to the facility in 2021. Resident #41 stated smoking was permitted at the time of admission, but the facility policy subsequently changed to a non-smoking facility. Resident #41 stated no accommodations were made for smokers, and smoking privileges were revoked. 3. Resident #54 was admitted to the facility on [DATE] with diagnoses including Quadriplegia and Major depressive Disorder. The 9/24/24 Quarterly Minimum Data Set (assessment tool) documented Resident #54 was cognitively intact. The Comprehensive Care Plan titled non-compliance last updated 5/22/24 documented educate resident on smoking, monitor resident for smoking regularly and upon return from leave of absence for signs of smoking. Any issues were to be reported to the supervisor immediately, and smoking cessation support was to be offered. The Comprehensive Care Plan Titled Smoking last updated 10/1/24 documented Resident is a known smoker, including smoking marijuana.The care plan instructed staff to check the resident's clothing regularly and upon return from leave of absence for evidence of unsafe smoking practice. The smoking policy was to be reviewed with the resident and family upon admission and as necessary. Smoking cessation support was to be offered. There was no documented evidence in Resident #54's electronic medical record that smoking cessation counseling, nicotine replacement options, and staff training in regards to smoking cessation programs had been offered when the facility changed its policy to prohibit smoking. During an interview on 12/15/2024 at 2:00 PM the Administrator stated when the facility went from a smoking facility to a non- smoking facility the needs and preferences of residents who previously smoked were not considered. 10 NYCRR 415.5(f)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview during the recertification, abbreviated (NY00359302), and extended surveys from 12/15/2024 to 12/22/2024, the facility failed to provide adequate supervision to prevent accidents related to smoking for 6 of 6 residents (#2, #6, #9, #29, #41 and #54) identified as smokers. Specifically, Resident #41 was a known smoker in a non-smoking facility and the facility failed to complete safety assessments or develop and implement a plan of care to ensure their safety, when it was known that the resident continued to smoke outside of the facility. On 11/1/2024 a fire was started on the outside patio when Resident #41 threw a cigarette butt into dry leaves. There were no facility staff supervising the resident during this smoking activity. Facility staff was alerted to the fire when the Director of Human Resources observed the smoke and fire from their office window. Facility staff had to remove residents from the area and extinguish the fire. Additionally, 2) Resident #54 had cigarettes and lighters with a strong odor of cigarette smoke in their room; 3) Residents # 2, #29, #41, and #54 were observed smoking on the patio without supervision. The patio was observed with cigarette butts in raised flower planters; there were no ashtrays or cigarette receptacles on the patio. The facility was aware the residents continued smoking and did not complete safety assessments or provide supervision. This resulted in Substandard Quality of Care, with no actual harm, that was Immediate Jeopardy with the likelihood for serious adverse outcome to all 102 residents in the facility. Findings include: The facility Smoking Policy and Procedure dated 1/21/2022 documented residents could smoke, and the Nursing Supervisor would assess the residents' ability to smoke safely by completing a smoking assessment that included an evaluation of the resident safety awareness, judgement, cognitive ability, and manual dexterity. The policy listed designated times for smoking and supplies would be marked with the resident's name and kept in a locked drawer in the copy room. The facility Smoking Policy dated 6/23/2022 documented smoking would not be permitted by residents. The policy did not address how to accommodate the residents that were smoking prior to the policy change. The policy did not address resident smoking contracts, agreements or participation in smoking cessation programs. 1) Resident #41 was admitted to the facility on [DATE] with diagnoses of Paraplegia (an impairment in motor or sensory function of the lower extremities), Schizoaffective and Borderline Personality disorder(Mental illness) . The Minimum Data Set (resident assessment tool) dated 10/18/2024 documented the resident had moderately impaired cognition and did not document tobacco use. Resident self ambulates by wheelchair. Resident #41's smoking assessment dated [DATE] documented the resident could only smoke while supervised. There were no further directions guiding the resident during smoking activity. There were no other smoking assessments in the resident's medical record. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #41's smoking care plan dated 9/1/2023, and a care plan review note dated 6/28/2024, documented the resident was found smoking in their room. Interventions included to review smoking policy with resident and family on admission, readmission and as needed. Staff will continue to counsel resident on a daily basis to ensure the safety of smoking in the facility is complied with. Resident has been referred to psychologist and psychiatrist due to his noncompliance with the facility policy of non-smoking, the resident will be educated and offered smoke cessation, visually observe residents clothing and surroundings regularly for signs of unsafe smoking including smoke, ashes and burns on hands and clothing. A nursing progress note dated 10/3/2024 documented staff approached Resident #41 regarding the aroma and visible smoke emanating from the resident's room. The resident was reminded that the facility was smoke free and instructed not to smoke in the facility. The resident acknowledged awareness of the policy and stated that smoking would not occur indoors in the future. A facility investigation dated 11/4/2024, completed by the facility Administrator, documented on 11/1/2024 around 4:15 PM, Resident #41 was smoking in the gazebo and put out a cigarette in the leaves behind the gazebo starting a fire. The root cause analysis determined Resident #41 was a smoker, frequently used the patio and put ashes on the gazebo and the ground surrounding it. The dry air and warm environment contributed to the cigarette butt lighting the dry leaves on fire. The immediate action was the patio was closed on the weekend and reopened on Monday 11/4/2024. The corrective action was Resident #41's patio privileges were revoked until further notice. The Director of Human Resources written statement, dated 11/1/2024, documented they smelled smoke from an open window, looked outside and saw a small fire starting to grow from behind the gazebo on the facility patio. Code Red was called, and they used extinguishers to put out the fire. The Social Worker was stomping the leaves, and Certified Nurse Aide #9 threw a fire blanket on the fire. Two residents were on the patio and taken back inside. Once the fire was out, they locked the patio door. There was no documented evidence Resident #41's comprehensive care plan was updated to reflect the need for increased supervision after the fire on 11/1/2024. During an interview on 12/15/2024 at 11:00 AM, at the entrance conference, the Administrator stated it was a non-smoking facility. They stated there were residents that smoked, and they were care planned for non-compliance. During an observation on 12/15/2024 at 1:15 PM, 12 cigarette butts were in the planter closest to the patio door with entrance into the building. The doors were labeled with no smoking signs. There were no ashtrays on the patio. During an interview on 12/15/2024 at 12:59 PM, Certified Nurse Aide #6 stated the facility was a non-smoking facility but there were residents that smoked. Cigarettes were taken from residents and held by the Administrator if the resident was a known smoker. They stated they believed there was a resident downstairs that got cigarettes and distributed them to other residents. Residents were not escorted outside to smoke by staff and could only smoke when on a leave of absence from the facility. They stated there was not a formal list of smokers but knew for certain that Resident #41 and Resident #6 smoked. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- at 1:09 PM Licensed Practical Nurse #8 stated the facility was a non-smoking facility. They stated they thought there were residents that smoked but they were not tracked or listed anywhere. During an interview on 12/15/2024 at 1:10PM the receptionist stated the residents were allowed to go outside alone on the patio and the patio was open from 7:00 AM to7:00 PM. They stated no one should be smoking on the patio, not staff, residents, or visitors. They stated Resident #54 has an uncle that visits twice a week and takes the resident up by the entrance to smoke. They stated Residents #2, #6, #9, #29, #41 and #54 were known smokers. During an interview on 12/15/2024 at 1:25 PM Certified Nurse Aide #5 stated Resident #41 was a known smoker, and they had been advised by facility administration to watch the resident closely. They stated they had smelled cigarette smoke in the facility in the past but had not observed matches, cigarettes, or lighters in the resident rooms. During an interview on 12/15/2024 t 1:34 PM Certified Nurse Aide #1 stated Resident #54 and Resident #41 smoked on the patio and sometimes in their rooms. -at 1:46 PM the Registered Nurse Supervisor#2 stated it was a non-smoking facility and when the residents went out with their families they could smoke. They stated there was not supposed to be smoking on the patio, but some of the residents smoked on the patio including Resident #54. During an interview on 12/15/2024 at 1:11 PM, Resident #41 stated they were allowed to smoke when they were admitted to the facility and the facility changed the rules without discussion with residents. They stated no accommodations were made for smokers. They stated they had been accused of smoking and privileges had been taken away. During a follow up interview on 12/15/2024 at 4:25PM, Resident #41 stated they were not given a smoking contract or education regarding noncompliance after the fire. During an interview on 12/15/2024 at 2:00 PM the Administrator stated the facility was non-smoking but had residents who smoked. The Administrator stated residents who smoked were care planned for non-compliance with the smoking policy. They stated they were aware that smoking unsupervised on the patio, and residents could come and go freely. The Administrator provided a list of residents that smoked including Residents #2, #6, #9, #29, #41, and #54. During an interview on 12/16/2024 at 11:30 AM, the Administrator stated they were notified of the fire on 11/1/2024 but was out of the facility and did not return until Monday 11/4/2024. An investigation was initiated, and statements were taken immediately after the incident from staff and residents. The patio was closed for the weekend. Video evidence and interviews indicated that Resident #41 caused the fire. Resident #41 was indefinitely banned from the patio. The fire was investigated, and no new systematic interventions were put in place to prevent unsupervised smoking. Resident #41's patio privilege was revoked on 11/1/2024 and reinstated on 11/18/2024. During an interview on 12/16/2024 at 11:58 AM, the Director of Nursing stated they were aware that residents smoked on the patio unsupervised. They stated they viewed the video from the fire that occurred on 11/1/2024 and reviewed Resident #41's statement after the incident. They stated they did not put any interventions in place after the incident and stated the Smoking care plan documented regular monitoring. They stated the monitoring was not documented. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 12/16/2024 at 12:27 PM, the Director of Human Resources stated on 11/1/2024 the window was open, and they smelled burning leaves. They went to the patio and saw the fire by the gazebo. They told the receptionist to call Code Red and grabbed the fire extinguisher and used it. Neither the Administrator or Director of Nursing were in facility, both were notified and neither returned back to the facility. The Administrator directed them to lock the patio door. They did view the video and it showed Resident #41 going outside to the patio and then back inside. The Director of Human Resources stated the flames were high. They stated they were aware that residents smoked on patio, but no one including staff, visitors, or residents were allowed to smoke on facility property. During an interview on 12/16/2024 at 12:44 PM, the Social Worker stated when the fire code was called, they ran to the patio, staff was struggling with extinguisher, so they stomped on the fire. They were not notified of any resident patio privileges being lifted. They stated they had not witnessed residents smoking out on patio but stated that they had smelled smoke. During an observation and interview on 12/16/2024 at 1:15 PM, with the Maintenance Director, 2 residents were observed smoking in the gazebo located on the patio. There was no staff present and no ashtrays or metal containers with self-closing devices in the area. The Maintenance Director stated they told the residents many times that smoking was not allowed but the residents did not care and still smoked. They stated they could smell cigarette smoke coming from residents' rooms. They further stated that administration was aware that residents smoked unsupervised on the patio. The Maintenance Director stated that they did not know if the wooden gazebo was fireproofed. They stated that it was a nonsmoking facility, and that was why there were no ashtrays. During the resident council meeting on 12/16/2024 at 1:30 PM, multiple residents stated they knew there was smoking in resident rooms as well as outside. They stated they could smell both weed and cigarettes. The residents stated there was once a fire outside caused by smoking. The Resident Council did not complain about the smoking as a group. However, during the meeting several residents stated that they have complained to staff about residents smoking in the facility. During an observation on 12/17/2024 at 11:18 AM, Resident #41 was self-propelling their wheelchair on the patio heading to the gazebo. At the gazebo the resident took out their lighter and cigarettes, lit the cigarette and started smoking. No staff were observed monitoring the resident, patio area, or gazebo. During an observation on 12/17/2024 at 1:32 PM, Resident #41 was observed smoking cigarettes on the patio with Resident #6 and Resident #29. No staff was present on the patio while the residents were smoking. During an interview on 12/22/2024 at 2:30 PM, the owner of the facility stated they were aware the residents smoked, and they had some problematic residents which they had been trying to discharge. They stated the issue was not brought up at the Quality Assurance/Performance Improvement committee meetings. 2. Resident #54 was admitted to the facility on [DATE] with diagnoses including nicotine dependence, cannabis dependence, quadriplegia and muscle spasms. The Minimum Data Set, dated [DATE] documented intact cognition and functional limitations in range of motion to both upper and lower extremities. Resident utilizes a motorized wheelchair for mobility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A smoking evaluation, dated 7/8/2021, documented Resident #54 could smoke with supervision only. There were no other smoking assessments in the resident's medical record to determine if the resident could smoke safely. The care plan titled Non-Compliance last updated 5/22/2024, documented interventions to educate the resident on the nonsmoking policy, monitor resident for smoking regularly and upon return from leave of absence for signs of smoking. Report any issues to the supervisor immediately and smoking cessation support was to be offered. There was no documented evidence that smoking cessation materials were ordered or administered to the residents who smoke. The care plan titled Smoking last updated 10/1/2024, documented Resident #54 was a known smoker, including smoking marijuana. The interventions include to check the resident's clothing regularly and upon return from leave of absence for evidence of unsafe smoking practice. The smoking policy was to be reviewed with the resident and family upon admission and as necessary. Smoking cessation support was to be offered. A 12/4/2024 a physiatry note documented Resident #54 had bilateral upper extremity spasticity with some use of the right hand. On 12/15/2024 at 9:30 AM, Resident #54 was observed with smoking materials including cigarettes, 2 lighters and a dried shredded green/brown mix of stems, seeds, and leaves, on the resident's overbed table; a heavy odor of cigarette smoke was noted in their room. The resident was interviewed at the time of observation and stated the cigarettes and lighters belonged to them. They stated they smoked outside on the patio, without staff present and lit their own cigarettes. During an observation on the patio on 12/15/2024 at 1:15 PM 12 cigarette butts were identified in the planter closest to the patio door leading to the building. The doors were clearly marked with No Smoking signs. When interviewed on 12/15/2024 at 1:34 PM, Certified Nurse Aide #1 stated Resident #54 and Resident #41 smoked on the patio and sometimes in their rooms. 3. Resident #29 was admitted to the facility on [DATE] with diagnosis of Schizophrenia (mental disorder) diabetes and anxiety disorder. The 10/14/2024 Quarterly Minimum Data Set documented Resident #29 demonstrated intact cognition and is dependent on staff for activity of daily living. Resident utilizes a wheelchair for mobility. Review of the electronic health record revealed Resident #29 had no care plan for smoking or non-compliance. During an interview on 12/15/2024 at 1:27 PM, Resident #29 stated there were residents in the facility who smoked outside at night. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation of the patio on 12/15/2024 at 4:18 PM, Residents #29 and #2 were outside the patio door on their way into the facility. A strong odor of cigarette smoke was present, no staff members were observed providing supervision on the patio. The residents were interviewed at the time and Resident #29 stated they were not smoking but Resident #2 was. Resident #2 was aphasic (a disorder that impairs the ability to communicate) but shook their head no. Resident #29 stated they were allowed to smoke when they were admitted to the facility and one day they were told they could no longer smoke at the facility. During an observation on 12/16/2024 at 1:15 PM, with the Director of Maintenance present, Residents #29 and #54 were observed smoking in the gazebo located on the patio without supervision. Resident #29 was interviewed at the time and stated that they discarded their ashes in the snow. During an observation on 12/17/2024 at 1:32 PM, Resident #6, Resident #29, and Resident #41 were observed smoking cigarettes on the patio without staff supervision. The facility was notified of the Immediate Jeopardy on 12/18/2024 at 4:39 PM. The Immediate Jeopardy was lifted on 12/21/2024 prior to the completion of the survey based on the following corrective actions: 1. The Smoking Policy was reviewed and updated to include that residents admitted to the facility prior to the implementation of the nonsmoking policy would be given smoking privileges. These residents who desired to smoke would be permitted to do so if the facility Interdisciplinary Team determined that the practice was safe for the residents, and they do so in the facility designated area. 2. A nursing assessment by a Registered Nurse was done for all smokers. They examined the residents and clothing for any burns. This was completed this on 12/18/2024. 3. All residents that currently smoke were assessed to determine if they were safe to smoke or require supervision and or assistance. This was completed 12/18/2024. 4. Safe smoking contracts were established for residents that smoke. This was completed on 12/18/2024. 5. A safe smoking area 30 feet from the building was established on 12/18/2024. 6. Appropriate receptacle for cigarettes butts was installed. On 12/18/2024 the receptacle was ordered with a delivery date 12/23/2024. On 12/20/2024 a small metal step-on garbage can that self-closed was installed. Surveyors observed garbage can being utilized during smoking activity. Two residents (#29, #41) were observed smoking on the patio under staff supervision. Cigarettes were disposed of in the can under the supervision of the facility staff. On 12/21/2024 at 10:00 AM, Residents #54, #29, #2 and #41 were observed smoking on the patio in the designated area under staff supervision. The small metal step-on garbage can was in use. 7. Sign for supervised smoking area was posted on 12/18/2024. 8. Smoking aprons were placed by exit to patio for those residents assessed to need an apron. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 12/21/2024 two smoking aprons were observed stored in two tier plastic storage bins by the [NAME] room door. 9. A standard size all-purpose fire extinguisher was located near the patio door on 12/18/2024. 10. Smoking materials for all residents were removed from resident rooms and placed in a locked medication cart, completed 12/18/24. 11. Supervised smoking times were assigned for 10:00 AM, 2:00 PM and 6:30 PM; doors were locked when smoking was not in session, completed 12/18/2024. 12. Schedule of staff supervision was completed 12/19/2024. 13. Care plans for all 6 smokers were completed for safe smoking on 12/19/2024. 14. Physician orders for each smoker documented residents were care planned to smoke in facility designated area only. 15. The facility employs 109 staff members. Of these, 102 completed the in-service training, including supervisors. Dates of the in-service were 12/18/2024, 12/19/2024 and 12/20/2024. A sample of staff members from Nursing, Rehabilitation, Administration, and Recreation were interviewed and verified they received the education. 16. All supervisor staff were educated on facility procedures particularly their role to call 911 in the event of a fire. 17. An hourly smoking monitoring log was maintained to check resident rooms for signs of smoking. 18. The patio door was locked and remained locked except during the smoking times. Staff was observed supervising the smokers, unlocking the door to allow the residents into the smoking area and locking the door when smoking was completed. 10 NYCRR 415.5(f)(2)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3) Resident #89 had diagnoses that included, but not limited to, Unspecified Dementia, Depression and Generalized Anxiety Disorder The Annual Minimum Data Set (an assessment tool) dated [DATE] documented severe Cognitive Impairment, Antipsychotic, Antianxiety, Antidepressant, Anticonvulsant use, no therapies or other special treatments. Pharmacy Consultant recommendation from the medication regimen review dated [DATE] documented incorrect indication for Montelukast (medication for allergies and asthma). Facility unable to provide Physician/Nurse Practitioner acknowledgement or response to recommendation. Current order documented Montelukast 10 milligram tablet once daily at bed time for high blood pressure. Seasonal allergic rhinitis listed as related diagnosis. Pharmacy Consultant recommendation from the medication regimen review dated [DATE] documented recommendation to evaluate the long term use of Miconazole cream (anti-fungal cream). Facility unable to provide Physician/Nurse Practitioner acknowledgement or response to recommendation. Current order documented Miconazole nitrate 2 % topical cream apply by topical route 3 times per day every shift and as needed. During an interview on [DATE] at 4:42PM with Nurse Practioner #1, they stated the Nurse Managers review the Pharmacy Consultant's recommendations and then they give them to the Nurse Practitioner to review, and sign off. Stated that they do get them monthly. Stated that the nurses correct the errors they can. Those recommendations that cannot be changed by nursing, they review, address, and sign off on. During an interview on [DATE] at 04:59 PM with the Director of Nursing, they stated that the entire Medical group receives the Pharmacy Consultant's recommendations via email. They stated that the nurses will review the changes that were recommended and change those that they can. Then the Nurse Practioner or Physician will review and sign off. The recommendations that can't be addressed by nursing are reviewed and addressed by the Nurse Practitioner or Physician. They then sign off on it. Stated that some of the Pharmacy Consultant's recommendations were being missed and the process needed improvement. 10NYCRR 415.18(c)(2) (continued on next page)

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	335657	A. Building B. Wing	12/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Campbell Hall Rehabilitation Center Inc	23 Kiernan Rd Campbell Hall, NY 10916

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review conducted during the Recertification Survey completed on [DATE]-[DATE], the facility did not develop and maintain policies and procedures for the monthly drug regimen review. The facility did not ensure that the attending physician, the facility's medical director and the Director of Nursing received and acted upon the Pharmacy Consultant's recommendations within a timely manner and documented in the medical record that the identified irregularities had been reviewed and what action should be taken for 3 of 5 residents reviewed for unnecessary medications (#9, #79, and #89). Specifically, 1) Resident # 9 had no documented follow up for drug regimen reviews from [DATE]. 2) Resident # 79 had no documented follow up for drug regimen reviews from [DATE] and [DATE] and 3) Resident #89 had irregularities documented by the Pharmacy Consultant for reviews performed on [DATE] and [DATE] with no evidence of physician review and response. The findings are: The facility did not provide a facility policy for Drug Regimen Reviews which would document the process by which the Pharmacy Consultant performs their review monthly, makes recommendations based on their review and the process by which the physician addresses those findings with documentation in the resident record. 1) Resident #9 had diagnoses of Chronic Respiratory Failure, COPD, Schizoaffective disorder, Hypertension, Rheumatoid Arthritis. The Minimum Data Set, an assessment tool, dated [DATE] documented the resident had intact cognition, verbal behaviors directed towards others and had a history of rejection of care. The Physician orders as of [DATE] document the resident was prescribed Donepezil 10mg 1 tab at bedtime for Alzheimer's insomnia (original order [DATE]), Duloxetine 60 mg capsule 2x day for Major Depressive Disorder (original order [DATE]), Eliquis 2.5 mg twice a day for hypertension (original order [DATE]), and Lyrica 75mg - 1 cap 3 x day for Mood disorder (original order [DATE]). The Pharmacy Consultant's drug regimen review document dated [DATE], recommended that based on their findings the indication for Eliquis and Lyrica were incorrect, please correct. There was no signature or response indicating the physician reviewed or responded to the finding. The physician orders reviewed on [DATE] documented there were no changes made to the indication for Eliquis or Lyrica. 2) Resident #79 had diagnoses that included Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus and , malignant neoplasm of kidney. The Minimum Data Set, an assessment tool dated [DATE] documented the resident had severe cognitive impairment and required supervision for eating and substantial assistance for oral hygiene, toileting hygiene, shower upper and lower body dressing. The Physician Orders dated [DATE] documented, the resident was prescribed Sertraline 50mg for Major Depressive Disorder. On [DATE] the physician orders documented the resident was prescribed Quetiapine 100mg - 1 tab twice a day for Major Depressive Disorder with psychoses symptoms and Clonazepam 0.5mg - ½ tab (.25mg) every eight hours for 30 days as needed for anxiety. On [DATE] the physician ordered Tramadol 50mg - 1 tab three times a day for pain. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pharmacy Consultant's recommendation from the drug regimen review performed [DATE] documented that the Clonazepam ordered [DATE] for 0.5mg, one half tablet (.25 mg) every eight hours as needed for 30 days was still active and needed to discontinued. The Pharmacy Consultant's review performed on [DATE] documented, Clonazepam ordered [DATE] for 30 days, not yet discontinued. Please discontinue and address medication errors. There was no evidence the recommendation was addressed by the physician until [DATE] when the order was changed. The resident had received an extra dose of the Clonazepam after the order expired but was not removed from the Medication Administration record. During an interview on [DATE] at 04:44 PM with Nurse Practitioner #28 who stated they receive the Pharmacy Consultant's drug regimen review reports from the nurses and will usually review and sign off on them. They stated the diagnoses are corrected by the nurses and then the nurses sign off on the pharmacy review record. The Nurse Practitioner #28 stated they were not sure what happened in September when a correction of the diagnoses was requested and does not look over medication orders to see that the diagnoses are correct. During an interview with the Director of Nursing on [DATE] at 04:57 PM they stated they receive the pharmacy reviews and will look at them to see if there is any nursing things that need to be done and delegate that to the nurses. The Physicians and Nurse Practitioners get the reviews also and they are supposed to sign off and send them back to the Director of Nursing. I do not keep track of who sends them back or when. The Director of Nursing stated they recently had a meeting with the Nurse Practitioners and told them there needs to be improvements.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. FACILITY Extended Survey Based on observation, record review and interview conducted during a recertification, abbreviated, and extended survey from 12/15/24-12/22/24 (complaint # NY00359302), the facility did not ensure that operative oversight for an effective system was in place to maintain health, safety, and the highest practicable well-being of residents. reviewed for accidents. Specifically, 1) the facility failed to provide adequate supervision to prevent accidents from smoking for 1 out of 3 residents reviewed for accidents. The facility Administrator did not ensure that smoking was not allowed in the facility grounds. 2) The facility Administrator did not ensure that employees were periodically instructed and followed the general fire procedures in accordance with the facility's Fire Emergency Plan, or that it conducted the required number of fire drills per quarter. 3) The Administrator did not ensure that its emergency preparedness plans were updated and that staff were trained annually. 4) In addition the facility did not ensure that staff were offered the updated COVID-19 vaccinations. 5) The facility did not ensure adequate nursing staffing levels to meet the resident needs as documented in their facility assessments. The findings are: The facility was cited for the following areas of non-compliance. Details of these citations can be found in this Statement of deficiencies. F689- The facility failed to provide adequate supervision to prevent accidents related to smoking for 6 of 6 residents (#2, #6, #9, #29, #41 and #54) identified as smokers. Specifically, Resident #41 was a known smoker in a non-smoking facility and the facility failed to complete safety assessments or develop and implement a plan of care to ensure their safety, when it was known that the resident continued to smoke outside of the facility. On 11/1/2024 a fire was started on the outside patio when Resident #41 threw a cigarette butt into dry leaves. There were no facility staff supervising the resident during this smoking activity. 0711 Based on record review and staff interviews, the facility did not ensure that employees are periodically instructed and follow the general fire procedures in accordance with the facility's Fire Emergency Plan. This is evidenced by the fact that staff members did not respond appropriately to an actual fire emergency that occurred on 11/01/2024 at approximately 4:15 PM; the facility failed to activate the fire alarm and to contact the fire department upon discover of the fire emergency. 0712-Based on record review and staff interview, the facility did not ensure that fire drills were conducted quarterly on each shift, and that written records included which emergency fire conditions were simulated during each fire drill in accordance with NFPA 101: Life Safety Code. 0741-Based on observation, record review and staff interviews, the facility did not ensure that smoking was not allowed in the facility grounds for a smoke free facility. Specifically, the facility is a nonsmoking facility and smoking was witnessed during the survey. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	E004-Based on document review and staff interviews, the facility did not ensure that its Emergency Preparedness Plan was reviewed and/or updated at least annually. E0037-Based on document review and staff interviews, the facility did not ensure that emergency preparedness training was provided to all staff at least annually. E0039- Based on document review and staff interviews, the facility did not ensure that the emergency preparedness testing requirements were in compliance with the requirements set forth in 483.73(d)(2). Specifically, the facility did not participate in an additional full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based exercise. F725-The facility did not ensure sufficient nursing staff to provide nursing and related services to attain or maintain the well-being of each resident in accordance with the facility assessment. This was evident for 17 of 90 shifts from 11/20/2024-12/20/2024 during the staffing review. Specifically, the facility triggered a 1-star rating in the payroll-based journal report. A review of the Facility Assessment documented minimal staffing levels required to provide residents quality of care and services. The facility's actual staffing reports revealed that they did not meet those staffing levels the facility did not provide actual staffing as documented in their Facility Assessment. F887-Based on interview and record review during the recertification survey conducted 12/15/24-12/22/24, the facility did not ensure each staff member was screened, offered the COVID-19 vaccine, and provided education regarding the benefits, risks and potential side effects associated with the vaccine for 10 of 10 staff reviewed for COVID vaccines. Specifically, there was no documented evidence of immunization records for COVID-19 vaccine for Registered Nurse Supervisor #2, Receptionist #3, Licensed Practical Nurse # 21 Certified Nurse Aid #9#22, #23,#24, Physical Therapist #25, [NAME] #26 and Maintenance staff #27. During an interview on 12/15/2024 at 10:30 AM, the Administrator stated it was a non-smoking facility and they were aware there were residents that smoked. They stated residents that smoked were care planned for non-compliance with the smoking policy. They stated the patio was unsupervised, and the residents could come and go independently. The Administrator provided a list of 6 residents including Residents #2, #6, #9, #29, #41, and #54 who were identified as smokers. During an interview on 12/15/24 at 1:46 PM the Registered Nurse Supervisor stated this is a non-smoking facility when the resident go out with their family they smoke, they are not supposed to smoke on the patio, but some of the resident smoke on the patio. During an interview on 12/16/24 at 1:15 PM The Maintenance Director, stated that he does not know if the wooden gazebo is fireproofed. During an interview on 12/20/24 at 3:21 PM with the Director of Nursing who is also the Infection Preventionist on record, they stated they have not been offering and keeping track of COVID-19 vaccines for staff and had problems with staffing, so have not gotten around to getting the COVID-19 status for staff. The Director of Nursing stated they got pulled from one project to the other and had not gotten back to organize the offering of COVID-19 vaccines for staff. I do not have any staff declination forms for the COVID-19 vaccine to show you. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10NYCRR 483.70(1)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on observation, record review, and interviews conducted during the recertification, abbreviated (NY00359302), and extended survey from 12/15/24 to 12/22/24 it was determined the facility did not ensure a process or frequency for the reporting by the Administrator to the governing body. The method of communication was not documented, and the governing body failed to establish and implement procedures for a clear line of communication regarding the management and operation of the facility. Specifically, the facility failed to provide adequate supervision to prevent accidents from smoking for six residents who were known smokers. Several observations documented residents smoking on the patio and gazebo, despite the facility being a nonsmoking facility. A fire occurred on 11/1/24, on the patio due to a discarded cigarette butt. Findings include: The facility was cited under Tag F 689 at Immediate Jeopardy scope and severity J. The facility did not provide documented evidence of a Quality Assurance Performance Improvement plan or action to address identified issues related to smoking. The facility also did not have proper or thorough documentation or evidence of Quality Assurance Performance Improvement meetings to address residents smoking unsupervised on the patio and gazebo. During an interview on 12/15/24 at 10:30 AM, the Administrator stated that the facility was a non-smoking facility but acknowledged that residents smoked in the facility though their smoking was not in compliance with the facility's policies. The administrator stated that no Quality Assurance Performance Improvement meeting was held to address the issue of smoking, but that the residents that smoked were care planned for non-compliance. The Administrator stated that the patio and gazebo areas were unsupervised, and the residents could come and go at their discretion. The Administrator provided a list of 6 residents, resident #2, #6, #9, #29, #41, and #54 who were identified as smokers. During an interview with the Director of Nursing on 12/18/24 at 3:00 PM they stated that the facility is a non-smoking facility, that the residents that smoke have a non-compliance care plan, that they were not aware that the residents were smoking in their rooms, and that the smoking issue was not reported to the Quality Assurance/Performance Improvement committee. During an interview with the Medical Director on 12/22/24 at 1:00 PM they stated that they were not aware of residents smoking in the facility or that there had been a smoking related fire at the facility. The Medical Director stated that there were no agenda items related to smoking presented to the Quality Assurance/Performance Improvement committee. During an interview with the owner of the facility on 12/22/24 at 2:30 PM they stated that they were aware that residents smoke at the facility. The owner stated that the issue of smoking at the facility was not brought to the attention of the Quality Assurance/Performance Improvement committee. The owner added that they have some problematic residents which they have been trying to discharge. During a follow up interview on 12/22/24 at 4:00 PM the Administrator stated that the smoking issue was not brought to the attention of the Quality Assurance/Performance Improvement committee. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10NYCRR 415.26(b)(3)(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review and interview conducted during a Recertification survey from 12/15/24-12/20/24, the facility did not ensure infection control prevention practices were maintained to prevent the development and transmission of communicable diseases and infection and did not ensure there was a system for preventing, identifying, reporting, investigating, and controlling infection and communicable disease for all residents. Specifically,1) there was no evidence that a Water Management Plan was in place to prevent and control Legionella, a Facility Risk Assessment was completed, or that Legionella testing was performed within the last year, 2) the facility did not effectively implement accurate tracking and monitoring of infection and outbreak among residents to prevent further spread of infection and early identification of outbreaks and 3) the facility did not provide documentation of screening, administration or declination and education provided for 3 of 10 staff (Certified Nurse Aide #9, Registered Nurse Supervisor #2 and Receptionist #3) reviewed for influenza vaccination and 10 of 10 staff reviewed for pneumococcal vaccination (Registered Nurse Supervisor #2, Receptionist #3, Licensed Practical Nurse # 21 Certified Nurse Aide #9, #22, #23, #24, Physical Therapist #25, [NAME] #26 and Maintenance Staff #27). The findings are: 1) The facility's Policy and Procedure for Legionella updated on 6/2019 documented routine Legionella culture sampling and analysis will be performed every year, maintenance department employees will take a water sample from each of three zones annually, specified records will be retained, including the environmental assessment, the sampling and management plan, and any associated sampling results on the facility's premises for a minimum of three years and such records will be available to the Department of Health upon request. Review of the facility's Legionella records revealed the last lab sample for Legionella detection was collected on 02/08/2023 with an analyzed date of 02/21/2023. The report indicated Legionella was not detected. There was no documented evidence for Legionella testing within the last year. There was no documented evidence for completion of an Environmental Risk Assessment within the last year. There was no documented evidence that a Water Management Plan was in place to prevent and control Legionella. On December 19, 2024, at approximately 9:08 AM, the Administrator stated lab results provided for review were for the last test completed, and there had not been any Legionella testing done in 2024. On December 19, 2024, at approximately 2:30 PM, the owner stated they would search for the risk assessment and the water management plan and would provide it for review. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) The facility policy for Infection Control Surveillance, revised 9/8/2021 documented the Quality Assurance Performance Improvement Committee will review all resident infections as well as the usage of antibiotics, monthly so as to identify any trends and areas for improvement. The information is reported quarterly, as needed Director of Nursing or designee will establish Quality Assurance Performance Improvement projects to identify root cause of infections and update the facility action plans. The Infection Control Nurse/Staff Educator will identify the rate of infectious diseases and identify any increases in infection rates and will be addressed. Facility acquired infections will be tracked and reported by the Infection Control Nurse/Staff Educator quarterly at the Quality Assurance Performance and Improvement meeting. There was no documented tool to track current infection identified in the facility which may include resident symptoms, dates of initial surveillance, follow through of lab specimens, lab results, antibiotics and isolation precautions. During an interview with the Director of Nursing on 12/20/24 at 3:31 PM they stated they were the Infection Preventionist and were responsible for the Infection Control Program at the facility. The Director of Nursing stated they were aware the tracking should have been done. They did not know what infections were going on in the facility or if there was a cluster or an outbreak of a particular organism. 3) During a review of staff immunization records for influenza vaccine status, 3 of 10 staff reviewed (Certified Nurse Aide #9, Registered Nurse #2 and Receptionist #3) did not have documentation of influenza status including, administration date, declination or if education was provided. In addition the facility did not provide documentation of pneumococcal screening, education or declinations for Registered Nurse Supervisor #2, Receptionist #3, Licensed Practical Nurse # 21 Certified Nurse Aide #9, #22, #23, #24, Physical Therapist #25, [NAME] #26 and Maintenance #27. During an interview with the Director of Nursing on 12/20/24 at 3:31 PM they stated they knew keeping track of immunization records was important but fell behind due to staffing issues. The Director of Nursing stated they did not have a master copy of staff who received or declined influenza vaccine and had not been screening or offering pneumococcal vaccination. 10NYCRR 415.19(a)(2)