

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 04/29/2025
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847</p> <p>Based on record review, and interviews conducted during the Abbreviated Survey (NY00377106), the facility did not ensure (Residents #1) of 3 residents reviewed for abuse, had the right to be free from abuse, neglect, or mistreatment. Specifically, Resident #1 was observed by Certified Nurse Aide #2 being hit on the arm by Certified Nurse Aide #1 while they were both providing care to the Resident. Additionally, upon review of Certified Nurse Aide #1's trainings/education, they did not have any abuse trainings while employed by the facility.</p> <p>The findings are:</p> <p>The 5/3/22 facility policy titled Prevention, Investigation, and reporting of Resident abuse, mistreatment documented that the facility does not permit verbal, mental, sexual or physical abuse, including corporal punishment or involuntary seclusion of residents.</p> <p>Resident #1 was admitted on [DATE] with diagnoses including but not limited to Dementia, Encephalopathy, and Parkinson's Disease.</p> <p>The 3/3/25 Admission Minimum Data Set documented that Resident #1 had severely impaired cognition.</p> <p>The 2/27/25 Abuse Care Plan documented that Resident #1 is at risk for abuse secondary to dementia. Interventions included monitoring skin changes and report all to nursing supervisor every shift.</p> <p>The 2/27/25 Abuse Care Plan, documented that there have been no review or revisions since 2/27/25.</p> <p>The Accident and Incident Report dated 4/8/25 documented that on 4/6/25, there was a staff to resident incident. Two aides stood Resident #1 up to change them, and while Resident #1 was being combative they hit Certified Nurse Aide #2, and Certified Nurse Aide #1 hit Resident #1 back on their arm. Certified Nurse Aide #1 was removed from the schedule.</p> <p>(continued on next page)</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 4/6/25 staff statement of occurrence by Certified Nurse Aide #2 stated that they along with Certified Nurse Aide #1 went to Resident #1 room to change them, and Resident #1 was fighting them and they held on to their hand. Certified Nurse Aide #2 stated that while Certified Nurse Aide #1 was washing Resident #2, and then went to the side near the window and Resident #1 got away from them. Resident #1 then hit Certified Nurse Aide #1, and Certified Nurse Aide #1 hit and Certified Nurse Aide #1 hit Resident #1 back on their arm. They then went out in the hallway and told the nurse, and they got the nursing supervisor.</p> <p>The 4/6/25 staff statement of occurrence by Certified Nurse Aide #1 documented that they were helping Certified Nurse Aide #2 with Resident #1 and Resident #1 was being combative hitting and punching them. Certified Nurse Aide #1 stated that they told Certified Nurse Aide #2 to leave Resident #1 alone, but Certified Nurse Aide #2 was insistent on continuing cares. Certified Nurse Aide #1 stated that Resident #1 then grabbed their arm and was punching them with the other hand. Certified Nurse Aide #1 stated that they pulled their arm from Resident #1's hands. Certified Nurse Aide #1 stated that they did not hit Resident #1. Certified Nurse Aide #1 stated that they left the room and told the nurse how combative Resident #1 was.</p> <p>During an interview on 4/15/25 at 1:21 PM, the Director of Nursing stated that the Certified Nurse Aide #1 should not have held Resident #1's hands down while the other aide was providing cares, and that if a resident is agitated, the Certified Nurse Aides should walk away and give the resident time and then reapproach. The Director of Nursing stated that abuse/behavioral health education has not been provided to staff and that they should have been done after the incident. The Director of Nursing stated the plan is to do another in-service on dementia and behavioral health, but the facility does not have a staff educator and has not had one for a while, and that they are responsible to do in-services until they get another staff educator but stated that it takes time because they are only one person.</p> <p>During an interview on 4/16/25 at 4:34 PM, Physician #1 stated that they were not aware of the incident on 4/6/25 where allegedly Resident #1 hit Certified Nurse Aide #1 and Certified Nurse Aide hit Resident #1 back on their arm. They would speak to the Director of Nursing about them not being made aware. Physician #1 stated that they expect to be notified of all incidents of abuse.</p> <p>During an interview on 4/17/25 at 4:16 PM, the Medical director stated that they were not made aware that Resident #1 was physically aggressive and was not aware of the abuse allegation incident that occurred on 4/6/25. The Medical Director stated they were informed by the Director of Nursing that on 4/17/25, Resident #1 was allegedly physically abused. The Medical Director stated that they expect to be notified of on all Accident or Incidents and abuse allegations so that Residents can be properly assessed, and interventions can be put into place so that abuse or neglect does not happen again.</p> <p>10 NYCRR 415.4(b)(3)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847</p> <p>Based on record review, and interviews conducted during the Abbreviated Survey (NY00377106) the facility did not ensure for 1 (Residents #1) of 3 residents reviewed for abuse, that all alleged violations involving abuse, mistreatment, or neglect, were thoroughly investigated. Specifically, 1) the facility investigation did not include a review of the facility camera footage, 2)The facility did not provide documented evidence that a report was made to law enforcement regarding the incident of alleged abuse by staff that occurred on 4/6/25, 3)The Medical Director was not notified of the alleged abuse of Resident #1 that occurred on 4/6/25 until 4/17/25. Physician #1 was notified of the incident on 4/16/25 and the investigative report was missing signatures from the Administrator, the Physician, and the Nurse Manager.</p> <p>The findings are:</p> <p>The Facility policy titled Abuse Identification last reviewed on 4/16/25 documented that the Abuse Investigation Coordinator (Director of Nursing) will coordinate, follow the investigation closely, and assure all elements are thorough and completed within 48 hours. All completed abuse investigations will be forwarded to the Administrator, Medical Director, Director of Nursing and Social Services for review and sign off.</p> <p>Resident #1 was admitted on [DATE] with diagnoses including but not limited to Dementia, Encephalopathy, and Parkinson's Disease.</p> <p>The 3/3/25 Admission Minimum Data Set documented that Resident #1 was cognitively severely impaired.</p> <p>The 2/27/25 Abuse Care Plan documented that Resident #1 was at risk for abuse secondary to dementia. Interventions included monitoring skin changes and reporting any changes to the nursing supervisor every shift.</p> <p>The Accident and Incident Report dated 4/8/25 documented that on 4/6/25, there was a staff to resident incident. Two aides stood Resident #1 up to change them. Resident #1 was being combative and hit Certified Nurse Aide #2, and Certified Nurse Aide #1 hit Resident #1 back on their arm. Certified Nurse Aide #1 was removed from the schedule.</p> <p>The 4/6/25 staff statement of occurrence by Certified Nurse Aide #2 stated that they (Certified Nurse Aide #1 & #2) went to provide care to Resident #1 the resident's room. Resident #1 was fighting them, and they held on to the resident's hand. Certified Nurse Aide #2 stated that while Certified Nurse Aide #1 was washing Resident #1, they went to the side near the window and Resident #1 got away from them. Resident #1 then hit Certified Nurse Aide #1, and Certified Nurse Aide #1 hit Resident #1 back on their arm. Certified Nurse Aide #2 then went out in the hallway and told the nurse, and they got the nursing supervisor.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 4/6/25 staff statement of occurrence by Certified Nurse Aide #1 documented that they were helping Certified Nurse Aide #2 with Resident #1 and Resident #1 was combative hitting and punching them. Certified Nurse Aide #1 stated that they told Certified Nurse Aide #2 to leave Resident #1 alone, but Certified Nurse Aide #2 was insistent on continuing cares. Certified Nurse Aide #1 stated that Resident #1 then grabbed their arm and was punching them with the other hand. Certified Nurse Aide #1 documented that they pulled their arm from Resident #1's hands. Certified Nurse Aide #1 documented that they did not hit Resident #1. They left the room and told the nurse how combative Resident #1 was.</p> <p>During an interview on 4/15/25 at 10:30 am, the Human Resources Director stated that Certified Nurse Aide #1 was currently not working at the facility, and Certified Nurse Aide #1 will be terminated.</p> <p>During an interview on 4/16/25 at 3:03 pm, the Administrator stated that they forgot to sign the internal investigation form for the alleged abuse incident on 4/6/25. The Administrator stated that the medical provider was not a part of investigation and did not review the investigation and should have been made aware. The Administrator stated there is an Accident and Incident Reporting team and they discuss incidents during morning reports. The Accident and Incident form for the incident that occurred on 4/6/25 is missing the signatures from the Administrator, medical provider, and the nurse manager. The Administrator stated that presently they do not have a 1st or 2nd floor nurse manager and that is why the Accident and Incident Reporting form did not have their signatures. In addition, there is no staff educator currently working at the facility. The Administrator stated they did not review the camera footage after the incident.</p> <p>During an interview on 4/15/25 at 1:21 PM, the Director of Nursing stated that they were not involved with initiating the Accident and Incident Report or the investigation of alleged abuse occurring on 4/6/25 and that they were not in the building. When they reported to work the Administrator had already initiated the investigation into the allegation of abuse on 4/6/25.</p> <p>During an interview on 4/16/25 at 4:34 PM, Physician #1 stated that they were not aware of the incident that occurred on 4/6/25 where allegedly Resident #1 hit Certified Nurse Aide #1 and Certified Nurse Aide #1 hit Resident #1 back. Physician #1 stated they must speak to the Director of Nursing about being made aware of all incidents of abuse in the facility. Them not being made aware. Physician #1 stated they expect to be notified of all incidents of abuse.</p> <p>During an interview on 4/17/25 at 3:28 PM, the Administrator stated they did not call the Certified Nursing Aide Registry to put in a referral. For on Certified Nurse Aide #1's certification. The Administrator stated going forward they will put in referrals for all staff involved in abuse. The Administrator stated that they did not call law enforcement because they call on a case by case, and that this case did not warrant a call to local police because Resident #1 did not want to press charges.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/17/25 at 4:16 pm, the medical director stated that they were not made aware that Resident #1 was physically aggressive and was not informed of the resident abuse allegation on 4/6/25. The Medical Director stated they were informed by the Director of Nursing on 4/17/25, that Resident #1 was allegedly physically abused and the resident had multiple physically aggressive behaviors prior to 4/17/25. The Medical Director stated that a Medical Doctor or a Nurse Practitioner is supposed to sign off on all internal investigations involving abuse and Accident and Incident reports. The Medical Director stated that they expect to be notified of on all Accident or Incidents and abuse allegations, so that they can assess the resident and possibly put medical interventions into place</p> <p>10 NYCRR 415.4(b)(3)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847</p> <p>Based on record review, and interviews conducted during the Abbreviated Survey (NY00377106 and NY00370944) the facility did not ensure that the Minimum Data Set (MDS) 3.0 assessments accurately reflected the residents' status at the time of the assessments for 1(Resident #1) of 3 residents reviewed. Specifically, the Minimum Data Set assessment inaccurately documented that Resident #1 was assessed to have no behaviors. The Certified Nurse Aide Documentation dated 2/27/25, 3/2/25, and 3/3/25 and the Nursing Progress notes dated 3/2/25 documented Resident #1 had multiple physically aggressive behaviors.</p> <p>The findings are:</p> <p>Resident #1 was admitted on [DATE] with diagnoses including but not limited to Dementia, Encephalopathy, and Parkinson's Disease.</p> <p>The 3/3/25 Admission Minimum Data Set documented that Resident #1 had severely impaired cognition, and no behaviors.</p> <p>The March 2025 Certified Nurse Aide Documentation documented that Resident #1 had a physically aggressive behavior on 2/27/25 involving kicking and hitting.</p> <p>During an interview on 4/17/25 at 3:32 PM, the Minimum Data Set (MDS) Coordinator stated that Resident #1's last Minimum Data Set, dated dated [DATE] was completed with based on a 7 day look back from 3/1/25. The Minimum Data Set (MDS) Coordinator stated that they complete the resident assessment by looking at the nursing progress notes and certified nurse aide documentation. The Minimum Data Set (MDS) Coordinator stated that upon review of the Certified Nurse aide documentation, a Certified Nurse Aide documented that Resident #1 had a physical aggressive behavior(kicking and hitting) on 2/27/25, and that when they previously looked at the Certified Nurse Aide documentation, there were 2 behaviors for that day; one that documented no behaviors and another one that documented behaviors. The Minimum Data Set (MDS) Coordinator stated it was an oversight on and they will modify the Minimum Data Set(MDS) information to capture the presence of behaviors as documented on the certified nurse accountability. The Minimum Data Set (MDS) Coordinator confirmed that because there were 2 behavior episodes documented on certified nurse aide accountability on 2/27/25. Once the behaviors are entered it will trigger a care area assessment.</p> <p>10NYCRR 415.11 (b)</p>		

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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** 50815</p> <p>Based on record review and interviews during an abbreviated survey (NY00377106, NY00370944), the facility did not ensure a comprehensive care plan was developed and implemented to maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 3 residents (Resident # 1 and # 2) reviewed. Specifically, 1) Resident # 1 had a diagnosis of dementia with behavior disturbances and no care plan in place to address these behaviors; 2) Resident # 2 had diagnoses of Schizoaffective disorder and Alzheimer's disease with no care plan in place to address the resident's verbal and physically aggressive behaviors.</p> <p>The findings include:</p> <p>A review of the facility's Comprehensive Care Plan Policy dated 8/10/2022 and last modified/reviewed on 1/14/2025 documented the facility is dedicated to providing personalized, high-quality care for our residents using a comprehensive resident assessment and care planning process. This process is designed to maximize and maintain each resident's functional potential and quality of life. A Comprehensive Care Plan (CCP) is crucial to achieving this, and we are committed to developing a Comprehensive Care Plan (CCP) for each resident by the 21st day of admission, updated quarterly, annually, upon readmission, and with any significant change of condition.</p> <p>Resident # 1 is an [AGE] year-old admitted to the facility on [DATE] with diagnosis that include but not limited to Dementia with behavioral disturbances, Parkinson, and Major Depressive Disorder with psychiatric symptoms.</p> <p>Admission Minimum Data Set (an assessment tool) dated 3/3/2025 documented a Brief Interview of Mental Status score of 3/15 denoting severe cognition impairment, with no behaviors present. Resident # 1 uses a wheelchair for locomotion, requires moderate assistance when eating, frequently incontinent of urine and always incontinent of bowel, and dependent with cares and transfers.</p> <p>No documented evidence of a behavior care plan can be found in Resident #1 electronic health record until after a resident to staff incident on 4/9/2025.</p> <p>Review of a physician order dated 2/27/25 documented an order to enter behavior note each shift; document behaviors, if any, and interventions to modify behavior, and effectiveness of interventions. Schedule: Every Day at 7:00 am-3:00 pm; 3:00 pm- 11:00 pm; 11:00 pm-7:00 am.</p> <p>A review of Certified Nurse Assistant Documentation identified behaviors on the following dates: 2/27/25 kicking/hitting; 3/2/25 kicking/hitting; 3/3/25 kicking/hitting; 3/12/25 kicking/hitting, abusive language; 3/13/25 kicking/hitting; 3/22/25 kicking/hitting, pinching/ scratching/ spitting, biting, abusive language, threatening behavior; 3/27/25 kicking/hitting; 3/30/25 kicking/hitting.</p> <p>A review of nursing behavior notes documented Resident #1 had behaviors on 3/2/2025, 3/6/2025, 3/15/2025, 3/16/2025, 3/17/2025, 3/21/2025, 3/23/2025, 4/2/2025, and 4/6/2025.</p> <p>(continued on next page)</p>		

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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>During an interview on 4/17/25 at 2:11 PM, the Director of Nursing stated that a Registered Nurse is responsible to initiate care plans. Revisions to the care plan are done by the discipline it refers to. The Director of Nursing stated that nursing/social workers can initiate and update behavior/abuse care plans. The interdisciplinary team reviews progress notes during morning meeting and the resident who is a victim of abuse would be seen by psychiatry/psychology. The Director of Nursing stated that Nursing and the Medical Team are responsible for reviewing the Certified Nursing Aide documentation. The Certified Nurse Aides are expected to report behaviors to the nurse. There should be documentation of behavior notes every shift even if the resident does not have behaviors. The Director of Nursing stated that nursing (Supervisors, Registered Nurses, and Director of Nursing) reviews the nursing progress notes for any indicators. The Director of Nursing stated that behavioral management care plan should have been put in place to address Resident # 1's combative behaviors and cannot answer why one was not initiated on admission on 2/27/2025. The Director of Nursing was also not sure why the abuse care plan was not updated after the incident on 4/6/2025. The Director of Nursing stated that they do not need to witness combative behaviors to initiate behavior care plan, as they are not in the facility 24 hours a day. Review of documentation from the staff is enough to initiate the appropriate care plan as needed.</p> <p>During an interview on 4/17/25 at 3:32 PM, the Minimum Data Set Coordinator stated that Minimum Data Set is a 7 days look back window, which takes into account the resident progress note by the nurses. The Certified Nurse Aide documentation also provides additional information. The Minimum Data Set Coordinator stated that the Certified Nurse Aides have 2 areas on their electronic documentation for Resident #1 to document behaviors. There were Certified Nurse Aide's documentation in one area indicating the Resident #1 had no behaviors and the second area indicated there were behaviors. The Minimum Data Set Coordinator stated during a review of the Certified Nurse Aide documentation history, they saw that there were 2 behaviors documented for the day. They stated it was an oversight and they must modify the Minimum Data Set. Clearly there is an error on review of documentation on their part and they will revise. If the Certified Nurse Aides are reporting that the resident is resistant to care, it should also be documented in the nursing progress notes which they will capture when reviewing. Lack of communication between the nurses and the certified nurse aides does not provide an accurate documentation to support the resident's behaviors. This in turn prevents the triggering of behaviors on the Minimum Data Set. The Minimum Data Set Coordinator stated that not having a physical behavior care plan is also a problem. Once the revision is completed, it will trigger for the Care Area Assessment to populate for a care plan to be created.</p> <p>2) Resident # 2 was admitted to the facility with diagnosis that include but not limited to Schizoaffective disorder, Alzheimer's disease, and Major Depressive Disorder.</p> <p>A Quarterly Minimum Data Set, dated dated [DATE] documented the Resident has a Brief Interview of Mental Status score of 13/15 denoting intact cognition, with verbal behaviors directed towards others and rejection to care. Resident has no impairments on upper or lower extremities and uses a wheelchair for locomotion. Requires setup for eating, supervision with bed mobility and transfers. Occasionally incontinent of urine and always continent of bowel.</p> <p>Review of a physician order dated 1/17/2025 documented an order to enter behavior note each shift, document behaviors, if any, and interventions to modify behavior, and effectiveness of interventions. Schedule: Every Day at 7:00 am-3:00 pm; 3:00 pm- 11:00 pm; 11:00 pm-7:00 am.</p> <p>(continued on next page)</p>		

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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>No documented evidence of a Behavior Care Plan or Abuse Care Plan found in Resident #2's electronic medical record.</p> <p>A review of nursing behavior notes documented Resident #2 had behaviors on 1/28/2025, 1/29/2025, 2/2/2025, 2/3/2025, 2/4/2025, 2/8/2025, 2/9/2025, 2/13/2025, 2/18/2025, 2/19/2025, 2/24/2025, 2/25/2025, 2/27/2025.</p> <p>During an interview 5/1/2025 at 11:24 am, the Director of Social Services stated Resident # 2 is a unique person because they are physically sick with a pacemaker and documented mental illness. There are times when Resident #2 is explosive and non-compliant with care. Resident # 2 is non-compliant with smoking and oxygen; can be impulsive. There are times when they also try to assist other residents. There was an incident where Resident # 2 attempted to throw a tv at resident that had dementia because they wanted the resident to be quiet. Resident # 2's care plans consist of redirection and reapproach. There are not too many interventions that can work with Resident # 2, and they have consulted the resident's guardian to get help with interventions for resident's behaviors. Interventions do not work because they are accusatory and aggressive. When the resident is transferred out to the hospital all their care plans will not automatically reactivate in the system.</p> <p>10 NYCRR 415.11(c)(1)</p>

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50815</p> <p>Based on record review and interviews during an abbreviated survey (NY00377106, NY00370944), the facility did not ensure a resident diagnosed with dementia, received the appropriate treatment and services to maintain their highest practicable physical, mental, and psychosocial well-being for 2 (Residents # 1, and # 2) of 3 residents reviewed. Specifically, 1) Resident # 1 had a diagnosis of Dementia with behavioral disturbances and did not have an individualized care plan with interventions in place to address the resident's verbal and physically aggressive behaviors to enhance their well-being and guide staff in managing the resident's care; 2) Resident # 2 had a diagnosis of Alzheimer's Disease with no behavioral care plan to address Resident # 2's verbal and physically aggressive behaviors.</p> <p>The findings are:</p> <p>Review of a behavior health policy dated 7/19/2024 and last revised on 8/13/2024 documented it is the policy of our nursing home to provide thorough and ongoing behavioral health training to equip our staff with the skills necessary to manage and support residents with behavioral health needs. The training program will focus primarily on the well-being of the residents while also addressing the mental health and resilience of our staff members.</p> <p>1) Resident # 1 had diagnoses that include but not limited to Dementia with behavioral disturbances, Parkinson, and Major Depressive Disorder with psychiatric symptoms.</p> <p>Admission Minimum Data Set (an assessment tool) dated 3/3/2025 documented a Brief Interview of Mental Status score of 3/15 denoting severe cognition impairment, with no behaviors present. Resident # 1 uses a wheelchair for locomotion, requires moderate assistance when eating, frequently incontinent of urine and always incontinent of bowel, and dependent with cares and transfers.</p> <p>Review of a physician order dated 2/27/25 documented an order to enter behavior note each shift; document behaviors, if any, and interventions to modify behavior, and effectiveness of interventions. Schedule: Every Day at 7:00 am-3:00 pm; 3:00 pm- 11:00 pm; 11:00 pm-7:00 am.</p> <p>A review of Certified Nurse Assistant Documentation identified behaviors on the following dates: 2/27/25 kicking/hitting; 3/2/25 kicking/hitting; 3/3/25 kicking/hitting; 3/12/25 kicking/hitting, abusive language; 3/13/25 kicking/hitting; 3/22/25 kicking/hitting, pinching/ scratching/ spitting, biting, abusive language, threatening behavior; 3/27/25 kicking/hitting; 3/30/25 kicking/hitting.</p> <p>A review of nursing behavior notes documented Resident #1 had behaviors on 3/2/2025, 3/6/2025, 3/15/2025, 3/16/2025, 3/17/2025, 3/21/2025, 3/23/2025, 4/2/2025, and 4/6/2025.</p> <p>A review of psychiatric progress notes documented the resident was seen on 3/5/2025, 3/12/2025, 3/19/2025, and 3/26/2025.</p> <p>(continued on next page)</p>		

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

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a Dementia - Impaired Judgement care plan dated 3/14/2025 documented a goal that resident will maintain current level of cognitive functioning; with an intervention to use simple words for instructions.</p> <p>Resident had an incident occur on 4/6/2025 during peri care Certified Nursing Assistant # 1 was reported for hitting Resident # 1 during cares.</p> <p>There was no documented evidence Resident 1's dementia care plan was reviewed and revised to include an individualized approach to address Resident #1's kicking, hitting, biting, abusive language, and threatening behaviors.</p> <p>2) Resident # 2 had diagnoses that include but not limited to Schizoaffective disorder, Alzheimer's disease, and Major Depressive Disorder.</p> <p>A Quarterly Minimum Data Set, dated dated [DATE] documented the Resident has a Brief Interview of Mental Status score of 13/15 denoting intact cognition, with verbal behaviors directed towards others and rejection to care. Resident has no impairments on upper or lower extremities and uses a wheelchair for locomotion. Requires setup for eating, supervision with bed mobility and transfers. Occasionally incontinent of urine and always continent of bowel.</p> <p>Review of a physician order dated 1/17/2025 documented an order to enter behavior note each shift, document behaviors, if any, and interventions to modify behavior, and effectiveness of interventions. Schedule: Every Day at 7:00 am-3:00 pm; 3:00 pm- 11:00 pm; 11:00 pm-7:00 am.</p> <p>A review of nursing behavior notes documented Resident #2 had behaviors on 1/28/2025, 1/29/2025, 2/2/2025, 2/3/2025, 2/4/2025, 2/8/2025, 2/9/2025, 2/13/2025, 2/18/2025, 2/19/2025, 2/24/2025, 2/25/2025, 2/27/2025.</p> <p>A review of a Cognitive/ Dementia care plan dated 1/17/2025 documented with a goal that Resident # 2 will be maintained at the highest practicable level of cognitive function as evidenced by resident will make needs known and have needs met over the course of the next review period. Interventions include reorient/redirect as needed (prn), establish and maintain effective and acceptable routine medical, reminders of previous family and community contacts via photos, conversation, reminiscing etc., provide recreational activities, provide assistance with Activities of Daily Living, Psychiatric Evaluation and follow up, anticipate resident needs.</p> <p>There was no documented evidence Resident 2's dementia care plan was reviewed and revised to include an individualized approach to address Resident #2's verbally and physically aggressive behaviors.</p> <p>(continued on next page)</p>

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/17/25 at 2:11 PM, the Director of Nursing stated that a Registered Nurse is responsible to initiate care plans. Revisions to the care plan are done by the discipline it refers to. The Director of Nursing stated that nursing/social workers can initiate and update behavior/abuse care plans. The interdisciplinary team reviews progress notes during morning meeting and the resident who is a victim of abuse would be seen by psychiatry/psychology. The Certified Nurse Aides are expected to report behaviors to the nurse. There should be documentation of behavior notes every shift even if the resident does not have behaviors. The Director of Nursing stated that nursing (Supervisors, Registered Nurses, and Director of Nursing) reviews the nursing progress notes for any indicators. The Director of Nursing stated that behavioral management care plan should have been put in place to address Resident # 1's combative behaviors and cannot answer why one was not initiated on admission on 2/27/2025. The Director of Nursing was also not sure why the abuse care plan was not updated after the incident on 4/6/2025. The Director of Nursing stated that they do not need to witness combative behaviors to initiate behavior care plan, as they are not in the facility 24 hours a day. Review of documentation from the staff is enough to initiate the appropriate care plan as needed.</p> <p>10 NYCRR 415.12</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>48847</p> <p>Based on record review, and interviews conducted during the Abbreviated Survey (NY00377106) the facility did not ensure that the Certified Nurse Aide training included dementia management and resident abuse prevention training for 1(Certified Nurse Aide#1) of 2 to ensure delivery of safe care. Specifically, the facility was unable to provide documented evidence that Certified Nurse Aide #1 was provided with abuse and/or dementia training.</p> <p>The Findings are:</p> <p>The facility policy titled Abuse Identification documented that All Staff are trained to identify physical abuse, psychological/ emotional abuse, sexual abuse, financial/material abuse, mistreatment, neglect, and self-neglect. All employees will be in-serviced on this policy initially, at the time of hire and annually thereafter by the Staff Development Coordinator</p> <p>On 4/15/25, Certified Nurse Aide #1's employee file to include in services and trainings were requested from the Human Resource Director, and they were unable to provide the requested information. The surveyor was only provided with a behavioral health training that documented that Certified Nurse Aide #1 had the training on 8/13/24.</p> <p>Review of Certified Nurse Aide #1's facility clock in time revealed Certified Nurse Aide #1 did not work in the facility on 8/13/24</p> <p>The Facility provided an in-service sign in sheet titled Behavioral Health on 4/15/25. The sign in sheet had no date when the in service was provided, no time duration for the in-service was indicated and there was no instructor's name documented.</p> <p>During an interview on 4/15/25 at 11:22 am, the Human Resources Director stated that they were unable to locate Certified Nurse Aide #1's training folder with their in-services. The Human Resource Director stated that the Staff Educator walked out of the job the previous week and that the Staff Educator prior also left.</p> <p>During an interview on 4/15/25 at 1:21 PM, the Director of Nursing stated that all staff should be in serviced on abuse/dementia care. They do not know if Certified Nurse Aide #1 was in-serviced on abuse or dementia because the staff educators keep leaving the job. The Director of Nursing stated that that Staff Educator left the facility and did not return. Until they get another staff educator, they are responsible for the in-services for the staff, and that no in-services have been done with any staff since they took over. The Director of Nursing stated that their plan is to do in-services on abuse, dementia and behavioral health, but since they are the only one, they will need time to complete.</p> <p>During an interview on 4/15/25 at 1:45 pm, Certified Nurse Aide #1 stated that they were never in-serviced on abuse, behavioral health, or dementia care. The only in service that was provided to them was about fires.</p> <p>(continued on next page)</p>		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/25 at 3:03 pm, the Administrator stated that they do not have a Staff Educator, and the position has been vacant for a week. Presently, there is no one performing that function. 10 NYCRR 415.26