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	08/05/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interviews and record review conducted during the recertification and abbreviated surveys (NY00383678), it was determined for 1 (Resident #111) of 4 residents reviewed for abuse that the facility did not ensure that Resident #111 was free from mental abuse, including abuse facilitated or enabled through the use of technology. Specifically, Resident #111 was recorded on live stream video during cares revealing their naked upper and lower body which was posted to social media when Certified Nurse Aide #22 carried their cell phone in their pocket. This caused Resident #111 to verbalize they felt violated and humiliated by Certified Nurse Aide's #22 actions.Findings are:The facility policy titled Photo and Video policy dated 5/30/25 documented the facility is dedicated to protecting the privacy, dignity, and rights of residents. The unauthorized capture, recording or dissemination of photos of residents, their families or their surroundings is strictly prohibited unless prior written informed consent is obtained.The facility's undated policy and procedure titled: Cell Phone Usage, documented employees of the facility are not permitted to make or receive cell phone calls at any time while working in resident care areas or any area where resident services are being performed. Cell phones must not be carried in these work areas. The facility's policy and procedure titled and dated 05/30/22: Prevention, investigation and reporting of Resident Abuse, Mistreatment, Neglect and Misappropriation of Resident Property, documented that the facility did not permit verbal, mental, sexual or physical abuse including corporal punishment or involuntary seclusion of residents. The policy is to ensure all measures are taken to prevent abuse. Resident #111 had diagnoses which included atrial fibrillation, major depressive disorder and hemiplegia.The 4/19/25 Minimum Data Set assessment tool documented Resident #111 had intact cognitive skills for daily decision making.The Facility Incident Report form, dated 6/15/25 at 1:00 PM, documented Resident #111 was in bed receiving cares as Certified Nurse Aide #22 was live streaming on social media. The facility had received a call about a video being live streamed within the nursing home. Certified Nurse Aide #22 inadvertently pressed record on their phone activating live stream video and went about their routine, performing cares. They stopped the recording when they were approached by the facility Nursing Supervisor about the recording. Certified Nurse Aide #22 was terminated.During an interview on 7/30/25 at 10:38 AM, Resident #111 stated when they found out about the incident, they felt violated and terrible about it. They had trouble trying to understand how and why it happened and was humiliated when they were told about the video. They have since spoken to the facility Social Worker and Psychiatric Nurse Practitioner and their family member about it and finds comfort talking. During an interview on 08/01/2025 at 12:50 PM, Registered Nurse #14 stated they had many in-services about phones and photos and videos of residents, but it was hard to monitor staff when they were administering medications. They stated they did their best to intervene when they saw staff using their phone during cares. During an observation of the video with the Administrator on 8/1/25 at 3:40 PM, Certified Nurse Aide #22 was observed walking in and out of Resident #111's room. On entry to room Resident #111, the resident was easily identified and there was full exposure of their head, chest, and legs wearing only a brief. During an interview on 08/01/25 at 3:40 PM, the Administrator stated the staff was clearly in violation of using their cell phone in a resident area which was against their policy. A video was made of the resident without wearing clothing. They further stated that whether or not it was intentional, abuse occurred. They stated that staff had been made aware of the facility policy. During an interview on 08/04/2025 at 1:52 PM, Certified Nurse Aide #22 stated they were not aware they were live streaming to social media while delivering care. They did have an in- service during their employment orientation and was aware cell phones were not permitted but had it on their person anyway. 415.12(h)(2)]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review conducted during the recertification and abbreviated (NY00368202) surveys from 7/29/2025 through 8/4/2025, the facility did not ensure that an alleged violation of abuse, was reported immediately, but not later than two hours after the allegation was made, for one (Resident #112) of 7 residents reviewed for accidents. Specifically, on 1/5/2025 Resident #112 and informed the staff that they had been raped. The facility did not report the rape allegation to the New York State Department of Health. The findings include: Resident #112 had diagnoses that included asthma, osteoarthritis, and anxiety. The Minimum Data Set (a resident assessment tool) dated 11/26/24 documented Resident #112 was cognitively intact and exhibited no behavioral symptoms. Resident #112 required assistance from staff to complete activities of daily living including personal care. The 1/5/25 at 10:23 AM progress note written by Registered Nurse Supervisor #17 documented a call from Resident #112's relative who reported that the resident was on the floor in their room and had been raped. Both floor nurses and Registered Nurse Supervisor #17 responded to the resident's room, where they found the resident sitting on the floor beside their bed. The resident was alert but disoriented, expressing confusion about their surroundings and repeatedly asking for clarification. The resident stated that someone had raped them and that they needed help. The resident stated that they had woken up and found their surroundings unfamiliar; the room looked different to the resident.The 1/6/25 at 1:43 PM Progress Note documented the Director of Social Services interviewed the resident, and the resident clarified that they had not been raped. During a telephone interview on 8/4/2025 at 9:59 AM, the resident's representative stated that the resident had called them to inform them that they were on the floor, naked, in their room on the morning of 1/5/25. The representative stated they then contacted the facility to request that someone check on the resident. A staff member later confirmed that they had seen the resident sitting on the floor in their room. During a telephone interview on 8/4/2025 at 1:39 PM, Registered Nurse Supervisor #17 stated they were working the overnight shift when the resident was observed sitting on the floor of their room and alleged rape. They stated they assessed the resident after their fall and found no injuries, and the resident later recanted their allegation of rape. They stated that the resident appeared disoriented to their surroundings and required staff to orient the resident to where they were. They stated that they informed both the Nurse Practitioner and the Director of Nursing and the physician about the incident. During an interview on 8/4/2025 at 12:54 PM, the Administrator stated Resident #112's allegation of rape had not been reported to the New York State Department of Health. They explained that the resident later retracted their claim of being raped. 10 NYCRR 415.4(b)(2)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review conducted during the recertification and abbreviated surveys (NY00378577) from 7/29/25 to 8/5/25, the facility did not ensure that the staff involved in the incident was suspended during the entirety of the investigation to prevent further potential abuse for one of four residents (#71) reviewed for abuse. Specifically, during an incident on 4/20/25 at 9:30 PM, Certified Nurse Aide #11 caused bruising to Resident #71's left hand after physically removing Resident #71's left hand from Licensed Practical Nurse #10's arm during a fingerstick refusal. The facility documented on the Internal Investigation Report that both Certified Nurse Aide #11 and Licensed Practical Nurse #10 were suspended pending investigation, although the facility did not suspend Certified Nurse #11 while the abuse investigation was being conducted. The findings included:A facility policy titled Prevention, Investigation and Reporting of Resident Abuse, Mistreatment, Neglect and Misappropriation of Resident Property reviewed 5/25/25 included: If the staff are involved in the alleged abuse, this employee should be suspended immediately pending the outcome of the investigationResident #71 diagnoses included: heart failure, chronic pulmonary obstructive disease, and diabetes mellitus due to underlying condition with hyperglycemia. The 1/16/25 quarterly Minimum Data Set (a resident assessment tool) documented Resident #71 was cognitively intact, required set-up / clean up assistance with eating, and was independent in dressing and transfers.A resident care plan titled At Risk for Abuse, updated 4/21/25 documented: Resident is at risk for abuse secondary to: increased need for assistance with activities of daily living. Interventions included: monitor skin changes and report all to nursing supervisor every shift, Social Worker evaluation upon admission, quarterly, yearly and as needed and refer to Psychiatry as needed. The 4/20/25 Accident / Incident Report documentation included: Resident #71 consented to a finger stick, got stuck and got upset at licensed practical nurse. Resident #71 grabbed the licensed practical nurse. The certified nurse aide came and removed Resident #71's hands from the licensed practical nurse. The immediate action to prevent reoccurrence documented: Licensed practical nurse and certified nurse aide suspended. The root cause analysis documented: Resident #71 was disoriented and grabbed the licensed practical nurse. The certified nurse aide tried to deescalate by prying Resident #71's hands off the licensed practical nurse. Injury: ecchymosis on left hand. The Internal Investigation Report dated 4/25/25 documentation included root cause analysis: The certified nurse aide attempted to free the nurse from Resident #71's hold and put their hands on Resident #71's hands to free the licensed practical nurses' arms. They were unfamiliar with the scope of physical abuse which included any action to control a resident's behavior. The immediate action documented: the licensed practical nurse and certified nurse aide were suspended pending investigation. During interviews on 07/29/2025 at 3:16 PM and 08/04/2025 at 5:53 PM, Resident #71 stated they had an incident with a nurse and certified nurse assistant after they completed a fingerstick which they refused. Resident #71 stated they were trying to push the licensed practical nurse away and were yelling patient refuses treatment and nurse did not stop and continued with the fingerstick. Resident #71 stated the certified nurse aide presented to room and helped the licensed practical nurse instead of helping the resident. Resident stated their left hand and wrist area were bruised after the incident.During an interview on 08/04/2025 at 6:11 PM, Certified Nurse Aide #11 stated they recalled the incident with Resident #71. They stated they were walking in the unit hallway and heard Resident #71 yelling for help. They stated when they walked into Resident #71's room, they observed Resident #71 digging their nails into Licensed Practical Nurse #10's arm. They stated they put on gloves and tried to loosen Resident #71's finger grip on Licensed Practical Nurse #10's arm. They stated they may have had their hand over Resident #71's left wrist. Certified Nurse Aide #11 stated they were asking Resident #71 to remove their hand from Licensed Practical Nurse #10's arm which Resident #71 did.During an interview and observation on 08/05/2025 at 10:10 AM, the Director of Human Resources / Staffing Coordinator stated Certified Nurse Aide #11 had a written counseling dated 4/24/25 by employee and dated 4/22/25 by Administrator. A review of the Counseling Report documented the disciplinary action for the counseling was Verbal, Written 1 and Written 2. The Suspension x __ days line was left blank. The Director of Human Resources/Staffing Coordinator stated they are not aware if Certified Nurse Aide #11 was suspended. A review of the staffing sheets for Certified Nurse Aide #11 documented they returned to work 4/22/25 3:30 PM-6:04 AM. During an interview on 08/05/2025 at 12:18 PM, the Administrator stated the investigation of alleged abuse was completed and findings were not submitted to the Survey Agency until 4/25/25. The Administrator stated they were aware that Certified Nurse Aide #11 returned to work at the facility on 4/22/25

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, record review, and interviews during the recertification and abbreviated surveys (NY00374242) from 7/29/25-8/5/25, the facility did not ensure each resident received care, consistent with professional standards of practice, to prevent and treat pressure ulcers for 2 of 4 residents (Residents #34 and #114) reviewed for pressure ulcers. Specifically, 1) Resident #34 had a physician's order to offload their heels in bed. The resident was observed in bed with their heels resting directly on the mattress and there was no pillow on the mattress to offload the resident's feet. The physician's order, dated 7/22/25, to offload heels in bed was not added to the resident's care plan or certified nurse aide instructions. 2) Resident #114 had pressure ulcers and wound care treatment was not provided consistently as ordered. The findings included:1) Resident #34 diagnoses included: vascular dementia, retention of urine and type 2 diabetes mellitus. The 7/9/25 Quarterly Minimum Data Set (a resident assessment tool) documented Resident #34 had severe cognitive impairment and required substantial/maximal assistance with bed mobility, toileting and bathing and was dependent on staff for transfers. The 7/22/25 physician's order documented to off load heels in bed. The 7/23/25 Skin Integrity care plan documented the Resident was at risk for skin breakdown related to decreased mobility, pain, incontinence. Interventions included Certified Nurse Aide evaluation of skin condition daily during care and report any skin abnormalities to nurse, encourage frequent position changes, prevent friction during transfers, resident care and bed mobility, and turn and repositioning schedule as recommended. There was no documented evidence that the care plan was updated to include the 7/22/25 physician's order to offload resident heels while in bed.The 7/22/25 hospital discharge summary note documented wound consult in hospital. Bilateral foot wounds. Scattered scabs to multiple toes with the most notable lateral on the bilateral bunion area, right foot. Recommendation: float heels with pillows. During observations on 07/30/2025 at 10:38 AM, 7/31/25 at 12:46 PM, and 8/1/2025 at 9:22 AM, Resident #34's bilateral heels were observed on their mattress, and not offloaded. Red scabs were observed on the resident's bilateral upper feet near and on their great toes. During an interview on 08/01/2025 at 9:22 AM, Certified Nurse Aide #15 stated they believe Resident #34's heels should be offloaded while they are in bed. They were not aware of an order or task for off-loading the resident's heels or if that was documented on the certified nurse aide instructions or tasks. They stated they will offload Resident #34's heels anyway as they probably should be. During an observation and interview on 08/04/2025 at 11:25 AM, Registered Nurse #5 stated Resident #34's bilateral heels should be offloaded. During a review of the electronic medical record, Registered Nurse #5 stated that a physician's order for Resident #34's heels to be offloaded was entered on 7/22/25 and that the skin integrity care plan for Resident #34 and the certified nurse aide instructions and tasks were not updated to reflect the physician order. They stated they are responsible for overseeing certified nurse aides on unit and for updating resident care plans. They stated that the staff member who entered the order could have updated the care plan and certified nurse aid instructions and tasks at that time. During an interview on 08/05/2025 at 1:40 PM, the Director of Nursing stated that when a physician's order is entered into the electronic medical record to offload a resident's heels, the expectation is that it be done. They stated that unit nurses should be assuring that physician's orders are added to resident care plans, interventions, and to the certified nurse aide instructions and tasks.2) Resident #114 had diagnoses that included end stage renal disease, diabetes mellitus, and heart failure. The facility Pressure Ulcer Treatment policy last reviewed 8/1/2025 documented general guidelines for the treatment of pressure ulcers and protocols based on the condition of the wound. Residents with congestive heart failure, renal disease, liver disease and diabetes, would be evaluated on a case-to-case basis. The 2/11/24 Quarterly Minimum Data Set documented moderately impaired cognition, no behaviors including refusal of care, dependent on assistance for most activities of daily living, incontinent bowel and bladder, unhealed pressure ulcers, two stage 4 ulcers (1 present on admission), interventions include pressure relief bed, chair, turn and position, nutritional management, pressure ulcer care, and application of ointment. The 12/22/2023 Skin Integrity Presence of Pressure Ulcer Care Plan documented Resident #114 had pressure ulcers. The goals were documented as remaining free of infection and that the wound will show signs of healing. Interventions included wound rounds weekly, turn and position every two hours, apply treatments as ordered by the physician, and air mattress. The 12/21/2023 physician's order documented check integrity and verify settings of air mattress every shift.The 12/21/2023 physician's order documented Santyl 250 unit/gram topical ointment, apply 1 applicatorful by topical route once daily in the morning to the coccyx wound after cleaning

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and interview during the recertification and abbreviated surveys (NY00032854) conducted from 7/29/25 to 8/4/25, the facility did not ensure that 1 of 7 residents (Resident #112) reviewed for accidents received adequate supervision and/or an environment free of hazards to prevent accidents. Specifically, Resident #112 was found on the floor of their room on 1/5/2025, and there was no documented evidence that a facility incident/accident report or investigation had been completed to determine a possible cause of the accident and to determine interventions to prevent further accidents.The findings include:The 5/22/2025 facility policy and procedure on resident accident/incident report policy documented the facility will promote and maintain a safe environment and maintain reports and surveillance of all resident's accidents and incidents. In addition, the facility will investigate and document all accidents and incidents and develop corrective measures to prevent reoccurrences.Resident #112 had diagnoses that included asthma, osteoarthritis, and anxiety. The 11/26/24 Minimum Data Set (a resident assessment tool) documented Resident #112 was cognitively intact. Resident required assistance from staff to completes their activities of daily living including personal care. The 1/5/25 at 10:23 AM progress note written by Registered Nurse Supervisor #17 documented a call from Resident #112's relative who reported that the resident was on the floor in their room and had been raped. Both floor nurses and Registered Nurse Supervisor #17 responded to the resident's room, where they found the resident sitting on the floor beside their bed. The resident was alert but disoriented, expressing confusion about their surroundings and repeatedly asking for clarification. The resident stated that someone had raped them and that they needed help. The resident stated that they had woken up and found their surroundings unfamiliar; the room looked different to the resident.The 1/5/25 at 6:55 PM progress note written by Nurse Practitioner #2 documented the reason for the residents' visit was related to the resident's fall. The resident was awake and alert in bed. According to nursing staff, the resident had been found on the floor that morning. Nurse Practitioner #2 observed no bruising or swelling and observed that the resident's range of motion was at baseline.During a telephone interview on 8/4/2025 at 9:59 AM, the resident's representative stated that the resident had called them to inform them that they were on the floor, naked, in their room on the morning of 1/5/25. The representative stated they then contacted the facility to request that someone check on the resident. A staff member later confirmed that they had seen the resident sitting on the floor in their room. When requested, the facility could not provide documented evidence of an incident/accident report for Resident #112's fall on 1/5/2025.During a telephone interview on 8/4/2025 at 1:39 PM, Registered Nurse Supervisor #17 stated they were working the overnight shift when the resident was observed sitting on the floor of their room and alleged rape. They stated they assessed the resident after their fall and found no injuries. They stated that the resident appeared disoriented to their surroundings and required staff to orient the resident to where they were. They stated that they informed both the Nurse Practitioner and the Director of Nursing and the physician about the incident. They stated an incident/accident report was initiated and was passed on to the next supervisor.During an interview on 8/4/2025 at 12:54 PM, the Administrator stated that a facility incident/accident report was not completed for the resident's fall on 1/5/25, because the allegation of rape made by the resident took precedence over the fall incident. During an interview on 8/5/2025 at 2:05 PM, the Director of Nursing stated that they would attempt to locate the incident/accident report for the fall on 1/5/25. In a follow-up interview on 8/5/2025 at 3:25 PM, the Director of Nursing stated that they could not locate the incident/accident report for Resident #112's fall on 1/5/25. 10 NYCRR 415.12 (h) (2)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, record review, and interview during the recertification and abbreviated surveys (NY00444179) from July 29, 2025, to August 5, 2025, the facility did not ensure that an effective pest control program was maintained to keep the facility free of mice in 2 of 2 Resident rooms (Resident #10 and Resident #66) reviewed. Specifically, Residents #10 and #66 complained of mice in their rooms and there was no documented evidence the rooms were inspected or that an effective pest control program was put in place. The findings are: The policy and procedure titled Pest Control revised 8/7/2025 documented: The Pest Control Policy outlines our approach to prevent, monitor, and control pest infestations within our premises, by applicable U.S. health and safety standards and regulations. Findings of any pest activity are reported to the Maintenance staff, and the Maintenance staff will forward findings to the pest control professional. A service inspection report dated November 12, 2024, documented the exterior building, rodent bait stations, and empty rodent feeding infestations at 75%–100%. A service inspection report dated December 10, 2024, documented that the exterior and all rodent bait stations were checked for activity, and bait was replaced as needed. A service inspection report dated December 24, 2024, documented the presence of ants in the kitchen behind the juice machine and the placement of ant gel bait in those areas to prevent and protect against seasonal and winter infestations. A service inspection report dated January 16, 2025, documented the treatment of ants with ant gel bait to prevent and protect against seasonal and winter invaders. A service inspection report dated January 28, 2025, documented a walk-through inspection conducted on the second floor, during which staff reported the presence of mice in the back room near the sink and refrigerator. Droppings were found in the cabinets, and glue boards were placed. There was no documented evidence that the residents’ rooms were inspected. During an observation and interview on 07/29/2025 at 10:00 AM, Resident #10 was in bed and stated that mice were present in the room, that mice had gotten on the table, the issue had been reported to staff, and that the problem persisted. The room was observed to be very cluttered, and no mouse droppings or traps were observed. During an interview and observation on 07/29/2025 at 11:22 AM, Resident #66 stated they have a mouse in their room which the observe frequently. They stated they have made unit staff and maintenance staff aware. An approximately five inches by three inch square hole was observed in wall behind resident bed during interview. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/01/2025 at 1:22 PM, Social Worker #19 stated Resident #10 had complained about mice in the room and no mice were seen. The office adjacent to the resident’s room had no mouse activity. The resident’s room was described as very unorganized. Multiple efforts had been made to organize the room, but the accumulation of items continued. During an interview on 08/01/2025 at 1:21 PM, Maintenance Worker #20 stated pest control companies were utilized at the facility but pest control staff did not observe resident rooms. They stated complaint regarding mouse sightings had been received from Resident #10. During an interview on 08/04/2025 at 11:45 AM, Registered Nurse #5 stated they were not aware of mouse in Resident #66’s room. They stated mice reports were placed in unit maintenance staff book on the unit. A review of the maintenance book did not document a report of any mice in Resident #66’s room, however there were numerous other mice concerns documented in book for the second floor, including resident rooms and the nurse station. During an interview and observation on 08/05/2025 at 8:41 AM, the Director of Maintenance stated the maintenance log book on units were checked daily. They stated some resident rooms reported having mice, mostly in resident rooms who keep food out. They stated a pest control company treated the facility monthly and a recent area of penetration was found outside building which was addressed. They stated staff encourage residents not to have excessive food in their rooms and encourage the use of plastic storage containers. They stated they were not aware of a mouse in Resident #66’s room. During an observation of Resident #66’ s room, the Director of Maintenance observed a hole in the wall behind the bed. They stated hole needed to be patched and food placed in plastic containers. 10 NYCRR 415.29(j)(5)