

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  12/10/2025
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record reviews during the recertification and abbreviated (2670229) surveys from 12/03/2025-12/10/2025, the facility did not ensure the resident's right to a safe, clean, and homelike environment. Specifically, Unit 2 had a strong urine smell, room [ROOM NUMBER] had a very strong urine smell that emanated into the hallway and surrounding areas, Unit 2 floors were visibly soiled or stained (both the hallways and the dining room), the Unit 2 shower room had used linens left on the shower chairs and bagged linens out of receptacles, and there was garbage that was observed on the floor in the shower room, dining room, and unit hallways. The Unit 1 dining room cabinet drawer had garbage in it. room [ROOM NUMBER] was cluttered with an unused oxygen concentrator. room [ROOM NUMBER] had boxes of supplies stored on the floor. The findings include:</p> <p>The facility policy provided was for terminal cleaning only, not routine cleaning.</p> <p>The blank facility environmental rounding log used, and provided for review, included the task of inspection to ensure that rooms are free of odors and that floors are clean and free of debris.</p> <p>During an observation of Unit 2 on 12/03/2025 starting at 9:22 AM, the unit floors were visibly soiled in the hallways and dining room. District 1 floors also had black stains/skids. There was garbage tucked in the handrail outside of room [ROOM NUMBER].</p> <p>During an observation on 12/03/2025 at 10:35 AM of the Unit 1 dining room a cabinet drawer contained empty food wrappers.</p> <p>During an interview on 12/03/2025 at 10:53 AM the Maintenance Director stated they provide supervision to the housekeepers. The Maintenance Director stated they were not aware the cabinets were being used in the Unit 1 dining room. It is the responsibility of dietary staff to clean the refrigerator, and the housekeepers would clean the cabinets.</p> <p>During an observation on 12/03/2025 at 11:24 AM, the floor in the Unit 2 dining area was soiled with visible dirt and dried substances and plastic packaging/wrappers and a plastic cup top were on the floor.</p> <p>During an observation on 12/03/2025 at 12:09 PM, a urine odor was present upon entering the dining room on Unit 2, diagonally from room [ROOM NUMBER]. The residents were preparing for lunch.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 12/03/2025 at 12:50 PM, room [ROOM NUMBER] contained an oxygen concentrator that Resident #4 stated was no longer in use and did not need to be kept in the room.</p> <p>During an observation on 12/04/2025 at 1:26 PM, room [ROOM NUMBER] was noted to have 2 cardboard boxes containing supplies on the floor. One on either side of the head of the bed.</p> <p>During an observation on 12/05/2025 at 11:27 AM on Unit 2, a urine odor was present in the hallway down District 3, and a urine odor was present in the hallway outside of room [ROOM NUMBER].</p> <p>During an observation on 12/09/2025 at 8:29 AM on Unit 2, a urine odor was present in the hallway outside of room [ROOM NUMBER].</p> <p>During an observation on 12/09/2025 at 8:36AM in the Unit 2 shower room, old towels were observed on a shower chair, an unused brief was sitting on a railing, and a bag of soiled linen was outside of the soiled receptacle in the room.</p> <p>During an interview on 12/09/2025 at 9:47 AM, Housekeeping Aide #19 stated that there was usually a housekeeping aide on each district on Unit 2. They were expected to clean their district daily and assist with other districts of the unit as needed. They were responsible to clean all the rooms and hallway floors on their district; mop, wipe everything down, dispose of any garbage. They thought the floors were stripped a couple months ago. Shared spaces on the unit were cleaned daily, dining room after meals, the shower room once daily, and the nurses station daily. They deep clean a resident room when there was a discharge, or if a resident was on precautions, but there was no schedule to perform deep cleaning in the rooms on a regular basis. There were no special instructions for any rooms to receive additional cleaning or attention on a regular basis, including room [ROOM NUMBER]. However, room [ROOM NUMBER] should be one of the first rooms tended to daily.</p> <p>During an interview on 2/09/2025 at 2:10 PM, the Administrator stated there was currently no housekeeping supervisor, but the facility had one until a few days ago. Housekeeping staff should have been cleaning the rooms, emptying garbage, and cleaning the floors daily. They were not aware of any rooms that received special attention or additional cleaning daily including room [ROOM NUMBER]. They personally checked the facility once or twice daily but did not perform rounds with the housekeeping supervisor on a regular basis. They stated the shower rooms should not have had used towels or soiled items left in the room. The resident rooms should have been cleaned daily, and odors should have been addressed if noticed on the unit. They stated the floors on the unit were cleaned daily and the dining room floors were cleaned after every meal. The floors had not been deep cleaned recently but should be done soon. The Administrator stated Certified Nurse Aides assist in clearing clutter from rooms. Typically, resident supplies were not kept in resident's rooms. If a resident was not using equipment like an oxygen concentrator, then it should have been removed from the room.</p> <p>10 NYCRR 415.5 (h)(1)</p>

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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>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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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>Based on observation, interview and record review during recertification and abbreviated survey (2637641) from 12/3/25 to 12/10/25, the facility did not ensure the residents rights to be free from physical abuse one (1) of four (4) residents reviewed for abuse (Resident #110). Specifically, Resident #110 was lying in bed when Resident #7, who had a history of wandering into other residents' rooms, wandered into Resident #110's room, and proceeded to hit Resident #110 with a Reacher (an assistive device), scratched their upper right arm causing their Dexcom sensor (a glucose monitoring system) to come off, leaving red scratch marks on their arm, and also threatened them with scissors. The findings include: The facility Policy and Procedure titled Abuse Identification, last modified 05/22/2025, documented all staff are trained to identify physical abuse, psychological/ emotional abuse, sexual abuse, financial/ material abuse, mistreatment, neglect, and self-neglect. Physical Abuse shall mean inappropriate physical contact with a resident of the facility, while such resident is under the supervision of the facility, which harms or is likely to harm the resident. Inappropriate physical contact includes, but is not limited to, striking, pinching, kicking, shoving and bumping. It also includes controlling behavior through corporal punishment. - Resident #110 was admitted to the facility with diagnoses including hemiplegia (one-sided paralysis) and hemiparesis (one-sided weakness) following cerebral infarction (stroke), diabetes, and major depressive disorder. The Minimum Data Set (MDS- an assessment tool) dated 07/24/2025, documented Resident #110 had intact cognition. Resident #110 required substantial to maximal assist for toileting, and showering; and needed partial to moderate assist for bed mobility and transfer. The At Risk for Abuse Care Plan dated 9/16/2025, documented Resident #110 was at risk for abuse. The goal was the resident would remain free of abuse. Interventions included to refer to psychiatry as needed, and social worker evaluation upon admission, quarterly, yearly, and as needed. - Resident #7 was admitted to the facility with diagnoses including dementia, schizophrenia and history of falling. The Minimum Data Set (MDS- an assessment tool) dated 08/01/2025, documented Resident #7 had severely impaired cognition. Resident #7 required substantial to maximal assist for bathing, bed mobility and transfer and was dependent for toileting and used a wheelchair for mobility. There were no behavior symptoms or wandering noted on this assessment. The care plan for Behavior dated 09/05/2023 documented Resident #7's behaviors included wandering and resistance to care. The care plan for Wandering/Elopement effective 2/14/2024 documented the goal was the resident would remain in appropriate areas. Interventions included Resident #7 would be monitored while up in their wheelchair. - The Incident Report dated 10/7/25 documented Resident #7 was observed in Resident #110's room by certified nurse aides and was resistant to leaving room. Resident #110 stated that Resident #7 hit them with their grabber tool, threw belongings and attempted to stab them with scissors. Resident #7 was removed from the room and put back to bed. The investigative summary dated 10/7/25 documented the following to be the route cause analysis: Resident #7 had severe cognitive deficit became confused and thought Resident #110 was in their room. Resident #7 behavioral reaction was due to their dementia diagnosis exhibiting behaviors associated confusion and accusations. The documented corrective action was to immediately separate residents, Resident #7 room was changed and both residents to be seen by social work. The conclusion was documented as Resident #7 did not recall the incident, both residents to be seen by social work and psych and Resident #7 will be on safety checks. Review of Resident #7's care plan had no documented evidence interventions were put in place, after the 10/07/2025 incident, to protect other residents from Resident #7's wandering and abusive behavior. Observation of the facility video camera footage dated 10/10/2025, revealed at 6:20 AM the Resident #110 was seen going down the hall of Resident #110's room and at 6:26 AM a staff member took Resident #7 back to the Day Room. At 6:29 AM Resident #7 was visible in the hallway again and at 6:31 AM they had gone past Resident #110's room and were at the end of the hall at the exit door. At 6:32 AM, Resident #7 went through the door undetected. During an interview on 12/10/2025 at 10:31 AM, Registered Nurse #22 stated they were made aware the Resident #7 had an altercation with Resident #110 on 10/7/25. Registered Nurse #22 stated they were not informed of any additional interventions implemented after the incident besides changing the resident's room. They further stated no new behavior monitoring interventions were put in place at that time. During an interview on 12/10/2025 at 11:23 AM, the Former Director of Social Work stated Resident #7 was moved after the incident with Resident #110. Resident #7 wandered and was exit seeking and was moved to the hallway that put them closest to the nursing station, which would allow nursing staff to visually see them when they crossed in front of the nursing station. The former Director of</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review and interview conducted during the Recertification and Abbreviated surveys( 2622747) from 12/3/2025 to 12/10/2025, the facility did not ensure all residents who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good nutrition, grooming, personal and oral hygiene for three (3) of six (6) (Residents #6 #76, #105) residents reviewed for Activities of Daily Living. Specifically, 1) Resident #6 was not provided showers as scheduled. 2) Resident #105 was observed on multiple days in bed into the afternoon and missed social activities and was not provided showers as scheduled. 3) Resident #76 was observed on multiple soiled in urine while in wheelchair in hallway. Findings include:</p> <p>The facility policy for Bathing dated 5/30/22 documented the facility will ensure proper personal hygiene of all residents. Non bedfast residents are showered or bathed in a tub twice per week and more frequently if needed. Unit Managers will maintain a bathing list, and the type of bath is recorded in the Resident Care Record.</p> <p>1) Resident #6 had diagnoses which included anxiety, schizoaffective disorder, and obesity.</p> <p>The quarterly Minimum Data Set assessment tool dated 9/26/2025 documented the resident had intact cognition, was dependent on staff for bed to chair transfer with a mechanical lift and was dependent on staff for showering and dressing. The resident was incontinent of bladder and bowel.</p> <p>The facility shower schedule located on the second floor documented Resident#6 was scheduled for a shower on Wednesdays and Saturdays during the evening shift.</p> <p>The resident's care plan for Activities of Daily Living dated 8/22/23 documented interventions which included weekly shower per schedule and as needed.</p> <p>The Resident Certified Nurse Aide documentation for showers from 10/1/2025 through 12/10/2025 documented there were 20 opportunities for a shower, but the resident only received five (5) showers (10/01/2025, 10/08/2025, 11/05/2025, 11/12/2025 and 11/29/2025). Two opportunities were not documented and there were two refusals. The remaining 11 opportunities were documented as bed baths.</p> <p>The nurse's notes were reviewed from 10/1/2025 to 12/10/2025 and there was no documentation of refusals.</p> <p>During an interview on 12/03/2025 at 10:44 AM, Resident #6 was in bed and stated they preferred to take showers but did not get them consistently because they needed to be transferred by mechanical lift, and it was extra work for the Certified Nurse Aides. They stated they were looking forward to a shower because they liked to get their hair washed.</p> <p>During a second interview on 12/09/2025 at 10:19 AM, Resident #6 stated they had a shower two weeks ago and only got bed baths in between their showers, but they would like to get showers twice a week. They stated they went to the beauty parlor today for hair washing and they were told their hair was so dirty it had to be washed twice. They stated they felt ignored when they were in bed all the time and not getting showered.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/09/2025 at 10:27 AM, Certified Nurse Aide #16 stated Resident #6 got showers on Wednesday and Saturday on the 3-11 shift. If staffing was not good, it would be hard to give the shower because Resident #6 required two (2) staff to utilize a mechanical lift for transfers. They stated it was important to get the resident out of bed to participate in activities including showers because it prevented skin breakdown and promoted socialization.</p> <p>During an interview on 12/09/2025 at 11:10 AM, Licensed Practical Nurse #25 stated Resident #6 should get a shower two times a week, on Saturdays and Wednesdays on the evening shift. They stated they did not know why showers were not being performed as scheduled. If a resident refused a shower the Certified Nurse Aides knew they needed to approach the resident again later and try to shower the resident. They stated Resident #6 liked to get showers and looked forward to it. They stated Resident #6 really needed showers due to incontinence and had often told them it felt good and made them feel better.</p> <p>2) Resident #105 had diagnoses including Depression, Alzheimer's disease and seizures. The quarterly Minimum Data Set assessment tool dated 10/27/2025 documented the resident had severe cognitive impairment and required substantial assistance for bathing.</p> <p>The Activities of Daily Living Care Plan dated 06/03/2022 documented the resident needed extensive assistance of staff for bathing, personal hygiene and eating.</p> <p>The Psychosocial care plan initiated 11/15/2025 documented the resident will maintain a positive psychosocial status by socializing with peers daily over next review. Interventions included to encourage resident to participate in plan of care and daily routine.</p> <p>The Activities care plan dated 7/24/2025 documented the goal was to maintain a level of socialization by joining two to three small group sessions each week. Interventions included to remind and invite the resident to activities, provide support for social interactions and place next to select peers.</p> <p>The facility shower schedule located on the second floor documented Resident#105 was scheduled for a shower on Mondays and Thursdays during the 7-3 shift.</p> <p>A nurse's note dated 10/13/2025 documented the resident refused their shower and a bed bath was performed. There were no other documentations of refusals of showers.</p> <p>The Certified Nurse Aide documentation for showers was reviewed from 10/1/2025 through 12/10/2025 and documented there was 19 opportunities for a shower, and the resident received three (12/1/2025, 11/27/2025, 11/24/2025). Six opportunities were not documented and there was one documented refusal. The remaining 10 opportunities were documented as bed baths.</p> <p>The December Activities Calendar documented that on 12/04/2025 a Jingle and Mingle activity was scheduled at 10:00 AM and on 12/05/2025 at 10:00 AM a seasonal art activity was scheduled and at 1:30 PM Eggnog and a movie was scheduled.</p> <p>During an observation on 12/04/2025 at 9:59 AM, the resident was in bed being fed by staff.</p> <p>During an observation on 12/04/2025 at 12:13 PM, the resident was in bed.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 12/05/2025 at 12:14 PM, the resident was in bed sleeping wearing a hospital gown.</p> <p>During an interview on 12/05/2025 at 12:43 PM, Certified Nurse Aide #6 stated they had 13 residents on their assignment and one shower to give. They stated they decided for themselves that today was a stay in bed day for Resident #105. They stated one staff called out and they could only do showers when staffing was better. They stated the nurse lets them know if residents need to be gotten up for dialysis or an appointment. Certified Nurse Aide #6 stated they made the determinations as to what residents they would get out of bed and did not discuss it with the nurse. They stated today they would change the briefs of the residents who were in bed and those residents would be staying in bed, as it was a hectic morning. They stated that this afternoon would be a more relaxed day.</p> <p>During an observation on 12/05/2025 at 1:51 PM, the resident was in bed wearing a hospital gown, sleeping. A revisit was made at 3:22 PM and the resident was still in bed wearing a hospital gown.</p> <p>During an interview on 12/05/2025 at 3:24 PM, Licensed Practical Nurse #25 stated they worked with two Certified Nurse Aides today and getting all the residents up who should get up was not manageable because the second district (28 residents/district) had more dependent residents and residents with behaviors. The residents had a routine and Certified Nurse Aides had to go by the resident schedules and the residents' schedules could be difficult to manage. They stated they felt bad for the Certified Nurse Aides because two (2) in a district was such a challenge. They did not help the Certified Nurse Aides because they were busy with the medication cart. They stated Resident #105 should have been out of bed as there was no stimulation in their room, and no interaction with others or socialization. They stated the Activities Department had an eggnog and cookies social and Resident #105 would have loved that activity. They stated they tell the Certified Nurse Aides to do their best and they leave the rest up to them. They stated were responsible for supervising the Certified Nurse Aides and ensuring all residents received care, but they were too busy administering medications.</p> <p>During an interview on 12/08/2025 at 1:45PM, Registered Nurse Supervisor #1 stated they were responsible for making sure the residents received good care. They stated they did rounds when they arrived in the morning and addressed problems. They stated Licensed Practical Nurses were responsible for making sure the Certified Nurse Aides were doing what they were supposed to be doing and if the Licensed Practical Nurse found problems, they would report to them.</p> <p>During a follow up interview on 12/09/2025 at 11:39 AM, Licensed Practical Nurse #25 stated when the Certified Nurse Aides see bed bath and shower, they think they can choose, but they should know better than that. The Certified Nurse Aides know what is expected and should be giving the showers according to the schedule. If they cannot, then they should let the nurses know.</p> <p>During a follow up interview on 12/09/2025 at 11:58 AM, the Registered Nurse Supervisor #1 stated showers were important for residents, and it was the Licensed Practical Nurse's job to make sure they were done by the Certified Nurse Aides. If they were not getting done, they needed to ask why.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/10/2025 at 11:34 AM, the Director of Nursing stated the Certified Nurse Aides received their Dementia training and the importance of showers on orientation. They stated staffing was not a good reason to not give showers and it needed to be done. They stated they were working on improving the supervisory staff and recently hire another supervisor. They stated they had good Licensed Practical Nurses, and they should be taking control. They stated the communication needed to improve between the Certified Nurse Aides and the Licensed Practical Nurses.</p> <p>3) Resident #76 had diagnoses that included, but not limited to, heart failure, depression, and benign prostatic hyperplasia.</p> <p>The Annual Minimum Data Set, dated [DATE] documented Resident #76 had intact cognition, no behaviors including rejection of care, was independent for toileting hygiene, dressing, footwear, and shower. They required maximal assistance for personal hygiene. They were not on a toileting program, occasionally incontinent urine, frequently incontinent of bowel, and medications included an antidepressant.</p> <p>The current Resident Nursing Instructions for Resident #76 documented no behaviors, showers preferred at start of shift, continent of bowel and bladder with occasional incontinence.</p> <p>The active Activities of Daily Living care plan effective 04/14/2013 documented the resident has self-care deficit including toileting and personal hygiene related to medical conditions. The goal was that resident was dependent for cares and would be maintained at optimal hygienic cleanliness. Interventions included supervision and setup or assist as requested for toileting and extensive assist of one staff for personal hygiene.</p> <p>The active Refusals care plan effective 1/13/2017 documented refusals to change clothing daily/showers, wound care, dressing change, podiatry visits, and fingersticks. Interventions included providing education on the importance of maintaining optimal hygiene. The care plan did not document that resident refused incontinence care, brief use, or assistance with toileting.</p> <p>The active Urinary Incontinence care plan effective 10/16/2025 documented resident has urinary incontinence with urgency and frequency. The goals documented resident will be free of skin breakdown secondary to incontinence and will have incontinence care rendered. Interventions included monitor for redness or skin breakdown during toileting/diaper change every 2 - 4 hours. Maintain toileting schedule with no specified scheduled.</p> <p>Review of the medical record found documented evidence from 10/01-12/10/2025, of any behavior including refusals of care; any education provided to resident on importance of regular incontinence care or hygiene practice; or any social work support related to refusals of care and hygiene practice.</p> <p>The Psychiatric Nurse Practitioner progress note dated 10/17/2025 documented continued self-care deficits noted. Escitalopram order was in place for the treatment of depression. No recommendations for changes in medication. Nursing would continue to monitor and document for signs/symptoms of anxiety, depression, and insomnia. The Psychiatric Nurse Practitioner progress note did not document any other interventions were recommended.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 12/03/2025 at 10:34 AM, Resident #76 was sitting up in a wheelchair in their room with a towel covering their lap, pants appeared wet, and a strong urine smell was present in the room.</p> <p>During an observation on 12/05/2025 at 3:22 PM Resident #76 was sitting at the nursing station on the phone, stained towel covering lap, pants visibly wet/soiled down both legs, and smell of urine emanating from them.</p> <p>During an observation on 12/08/2025 at 12:38 PM, Resident #76 was in their room, their bedding and blanket was soiled. The sheets had a dry yellow fluid stain, the fitted sheet had a large brown stain on the side of the sheet, there was a dry round stain on the bed pad, and strong urine smell in and around their room. At 3:48 PM Resident #76's room was observed with sheets, bed pad, blankets all soiled as they were at 12:38PM and there was a very strong odor of urine in and around the room. Resident #76's had a soiled towel in their lap.</p> <p>During an interview on 12/08/2025 at 3:50 PM, Certified Nurse Aide #17 accompanied this surveyor into Resident #76's room. They stated they just started their shift at 3PM but saw that the bedding needed to be changed. They stated Resident #76 had not refused their assistance with linens being changed or incontinence care.</p> <p>During an interview on 12/09/2025 at 9:30 AM, Certified Nurse Aide #16 stated Resident #76 allowed the room to be cleaned, including changing the bed sheets/linens, and refused care at times. They were not on a toileting program. They always kept a towel in their lap and allowed them to provide a clean one but did not always allow assistance with changing clothing.</p> <p>During an interview on 12/10/2025 at 9:35 AM, the Social Worker stated that Resident #76 was followed by another Social Worker who no longer worked at the facility. They stated they were not very familiar with Resident #76 and had not met with them. They were aware that Resident #76 had a history of incontinence and refused care at times.</p> <p>During an interview on 12/10/2025 at 11:11 AM, Registered Nurse Supervisor #1 stated Resident #76 was incontinent and did have a refusal care plan for incontinence care. They were aware that they could be soiled at times and that there was a strong urine smell in and around their room on the unit affecting themselves and other residents. They stated it could create dignity, skin, and general hygiene concerns. They spoke with the resident once regarding the effects on their skin, and they did not know that anyone specific was working with Resident #76 regarding their refusals on a regular basis. Resident #76 was followed by the Psychiatric Nurse Practitioner who had discussed the issue with the resident in the past. Registered Nurse Supervisor #1 was unable to provide documented evidence of recent discussion or new interventions to address it.</p> <p>10NYCRR 415.12(a)(3)</p>		

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  12/10/2025
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)
F 0686  Level of Harm - Actual harm  Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing.  (continued on next page)

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F 0686  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record reviews, and interviews conducted during the recertification survey, the facility failed to ensure that one (1) of five (5) residents (Resident # 106) reviewed for pressure ulcers received the necessary care and services to promote healing. Specifically, Resident #106 who was dependent for bed mobility was identified as having a Stage 2 pressure on the sacrum during an assessment by Registered Nurse Supervisor #1 on 10/16/2025. A wound consult was ordered which was not initiated until 11/05/2025. There was no documented evidence of wound assessments from 10/16/2025 to 11/05/2025. The first wound consult identified two (2) Stage 3 pressure ulcers on the right and left buttock. Additionally, there was no documented evidence of the wound progression from 11/12/2025 to 11/19/2025. Resident #106 was admitted to the hospital on [DATE] for worsening of pressure ulcer with a chronic-appearing dusky hue with scattered partial and full thickness ulcerations to the coccyx and bilateral buttocks. This resulted in actual harm to Resident #106 that was not Immediate Jeopardy. Findings include: The policy and procedure titled Pressure Ulcer Treatment last revised 08/01/2025 documented a treatment protocol shall be established for all identified Stage 2 pressure ulcers. The treatment objectives are to cover, protect, hydrate, insulate, and absorb exudate as appropriate. Care will be provided in accordance with the organization's Pressure Ulcer Treatment policy and procedure. A treatment protocol will be established for all identified Stage 3 pressure ulcers. The objective will be to cover, protect, hydrate, insulate, absorb, cleanse, prevent infection, and promote granulation. Resident #106 had diagnoses including diabetes (a blood sugar regulation problem), pressure ulcer (skin impairment) of sacral region (butt bone area), and acute kidney (organ in body for filtering waste) failure (loss of ability to filter waste). The admission Minimum Data Set (a resident assessment tool) dated 08/17/2025, documented Resident #106 had intact cognition, was dependent on staff for bed mobility, was frequently incontinent of bowel and bladder, was at risk for pressure ulcers and did not have any pressure ulcers. Skin and ulcer/injury treatments included pressure reducing devices for the chair and bed. The comprehensive care plan titled 'At Risk for Skin Breakdown Related to Impaired Mobility' dated 08/20/2025, documented the goal was the resident would be maintained with current skin integrity as evidenced by freedom from skin breakdown. Interventions included: complete a pressure ulcer risk assessment (Braden Scale), review quarterly and as needed, Certified Nurse Aide evaluation of skin condition daily during care and report any skin abnormalities to the nurse, the use of pressure reducing cushion when in wheelchair, skin barrier when performing perineal care, and encourage frequent changes in position. The Nursing-Resident Care Summary completed on 09/25/2025, documented the Braden Scale assessed the resident at low risk for pressure ulcer and documented the resident had no sensory perception impairment, was rarely moist, was chairfast, had no mobility limitation, adequate nutrition and a potential problem for friction and shear. Registered Nurse Supervisor #1's progress note dated 10/16/2025 at 9:34 PM documented they were alerted by the certified nurse aide and Licensed Practical Nurse #11 that Resident #106 had a 5-centimeter in diameter Stage 2 pressure ulcer to the sacrum. The wound bed was red and moist, and the surrounding tissue had erythema (superficial reddening of the skin). There was no exudate (drainage) from the site. The resident also had deep tissue injury (DTI) to the bilateral upper posterior thighs just below the buttocks. The findings were discussed with Nurse Practitioner #1. They would add the resident to wound rounds and place a foam dressing to the sacrum and place on a every two (2) hour turning schedule. The physician orders dated 10/16/2025 documented wound consult for new Stage 2 pressure ulcer to sacrum and deep tissue injuries to thighs; cleanse sacral wound with saline, pat dry and cover with foam dressing every 48 hours and as needed for soiling; turn every two (2) hours and float heels; only two (2) hours out of bed to chair; ensure gel cushion is in wheelchair. Licensed Practical Nurse #11's progress note dated 10/16/2025 at 10:57PM documented the certified nurse aide reported the resident had an open sore near the coccyx. The supervisor was notified, and treatment was administered per Nurse Practitioner #1 order. The area would continue to be monitored for signs of pressure ulcer development. Licensed Practical Nurse #8's progress note dated 10/17/2025 at 12:50 PM documented they noted a new open area on resident's buttocks, the nurse practitioner was made aware a new order to start zinc oxide once daily and follow up with wound care. The physician order dated 10/17/2025 at 12:54 PM documented zinc oxide 20% topical ointment once daily to buttocks. The physician order dated 10/29/2025 at 3:06 PM documented air mattress. A review of Resident #106's electronic medical record did not reveal any wound assessments from</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record reviews and interviews during a recertification and abbreviated survey (2637641) from 12/03/25 to 12/10/25 the facility did not ensure that each resident received adequate supervision to prevent accidents for one (1)( Resident#7) of six (6) residents reviewed for accidents. Specifically, Resident#7 who had a history of wandering by self-propelling in their wheelchair, accessed an alarmed stairwell door and fell down the stairwell in their wheelchair. The resident sustained two fractured vertebrae and a hematoma on their scalp.The findings include: Resident #7 was admitted to the facility with diagnoses including dementia, schizophrenia and history of falling. The Minimum Data Set (MDS- an assessment tool) dated 08/01/2025, documented Resident #7 had severely impaired cognition. Resident#7 required substantial to maximal assist for bathing, bed mobility and transfer and was dependent for toileting and used a wheelchair for mobility. There were no behavior symptoms or wandering noted on this assessment. The care plan for Behavior dated 09/05/2023 documented Resident #7's behaviors included wandering and resistance to care.The care plan for Wandering/Elopement effective 2/14/2024 documented the goal was the resident would remain in appropriate areas. Interventions included Resident #7 would be monitored while up in their wheelchair.The 8/6/25 Fall Assessment documented Resident #7 was a high risk for falls. It further documented they had a history of falls, wandering and confusion. The Incident Report dated 10/7/25 documented Resident#7 was observed in Resident #110's room by certified nurse aides and was resistant to leaving room. Resident #110 stated that Resident#7 hit them with their grabber tool, threw belongings and attempted to stab them with scissors. Resident#7 was removed from the room and put back to bed.The investigative summary dated 10/7/25 documented the route cause analysis was Resident #7 had severe cognitive deficit became confused and thought Resident #110 was in their room. Resident #7 behavioral reaction was due to their dementia diagnosis exhibiting behaviors associated confusion and accusations. The documented corrective action was to immediately separate residents, Resident #7 room was changed and both residents to be seen by social work. The conclusion was documented as Resident #7 did not recall the incident, both residents to be seen by social work and psych and Resident #7 would be on safety checks.Review of Resident #7's care plan had no documented evidence interventions were put in place including increased supervision after the 10/07/2025 incident to address Resident #7's wandering behavior and being an aggressor in a resident-to-resident altercation.The 10/7/25 Elopement Risk Assessment documented Resident #7 was a high risk for elopement.A nurses note dated 10/09/25 at 6:11PM documented the resident was an elopement risk and wore a wandergard on their left wrist.A nurses note dated 10/10/25 at 7:40AM documented at 6:35 AM staff responded to a door alarm by Disctric#2 hallway. Resident#7 was down the stairs with the wheelchair close to them. Resident#7 was observed on their back both legs extended and was able to move arms and legs without restriction. Skin break noted to the back of their head. The resident was alert and verbal and reported their head and back hurt. The Supervisor was made aware. Transferred by Emergency Medical Services at 0700AM.The Registered Nurse Supervisor #1's progress note dated 10/10/2025 at 8:44 PM documented Resident #7 returned from the Emergency Room. They spoke to the emergency room physician who communicated the resident had two (2) fractured lumbar transverse processes and would need pain management and follow-up with orthopedics. They were also diagnosed with a urinary tract infection and started on an antibiotic. Resident #7 had three lidocaine patches to the right hip.The 10/10/25 Incident Report documented Resident #7 fell down the stairs at 6:35 AM with injury/skin break to back of resident's head with moderate amount of bleeding. Resident #7 was observed lying in a supine position down the stairs at the end of district 2 hallway with their wheelchair by their side. When Resident #7 was asked how they fell the resident responded, my head and back hurt. The resident was sent to emergency room at 7:15 AM. A written statement from Certified Nurse Aides #28 dated 10/10/2025, documented they did morning care for the resident at approximately 5:30 AM and then the resident was in the Day Room. At around 6:25 AM, the resident was in the hallway wheeling toward the the rear door and they brought the resident back to the Day Room. They were in another resident's room providing care when they heard the alarm go off around 6:30 AM for the back door. They checked the back door and saw the resident down the stairs. They told the nurse on the floor and the Supervisor.The Internal Investigation Report by the Supervising Administrator, completed on 10/15/2025 documented on 10/10/25 the resident had a fall with mainr injurv and fell down the district 2 hallway alarmed door. The summary of investigator's findings was the</p>		

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F 0692  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide enough food/fluids to maintain a resident's health.  (continued on next page)

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review and interviews during a recertification survey conducted from 12/03/2025 to 12/10/2025, the facility did not ensure adequate nutrition care and services for two (2) of eight (8) residents reviewed for Nutrition (Resident #1 and Resident #3). Specifically, 1) Resident #1 had a 12% weight loss over five (5) months; a sacral wound with no supplemental protein to promote wound healing, and their meal intake was not consistently monitored. 2) Resident #3 had a 9.8% weight loss in six (6) weeks; they consumed less than 50% of over half of all meals served during the survey, and there was a delay in providing a dietary supplement for weight loss. Findings include: The policy titled Nutrition Assessment and Monitoring reviewed 09/04/2025 documented Nursing staff collect and report intake data daily. Care plans are updated immediately to reflect weight changes. The policy titled Unintended Weight Loss reviewed 09/26/2023 documented procedures to address poor intake and or unintentional weight loss: obtaining food preferences, additions of snacks and/or supplements, three-day food intake study, change in diet and diet consistency. 1) Resident #1 had diagnoses including sepsis, prostate cancer, and diabetes. The 10/31/2025 Minimum Data Set assessment documented the resident had moderately impaired cognition and required supervision with eating and had a Stage 3 pressure ulcer. The 06/24/2025 care plan titled Alteration in Nutrition and Hydration did not document any food preferences. The care plan titled Nutrition Status did not have any interventions. The 10/28/2025 Medical/Psychiatry note documented a voice mail was left for the next of kin to discuss Resident #1's weight loss and poor appetite. The resident's weight was 97 pounds, down from 101 pounds. The 11/26/2025 Physician order documented a no concentrated sweets diet, normal consistency, and thin liquids with special instructions of no added salt, renal diet. Resident #1's weight records documented on 06/13/2025 they weighed 106.6 pounds, on 07/02/2025 they weighed 104.6 pounds, on 08/01/2025 they weighed 101.2 pounds, on 09/12/2025 they weighed 96 pounds, on 10/15/2025 they weighed 92.8 pounds, on 11/23/2025 they weighed 93.8 pounds. The dietary readmission (hospitalized from [DATE]-[DATE]) note dated 12/02/2025 documented Resident #1 had a diet order of no concentrated sweets, no added salt diet with fair to good appetite, ordered take-out food, weight pending, and 11/25/2025 albumin 2.1 (Albumin is protein in the blood to measure nutrition status with a normal range of 3.4-5.4 grams/dL). The plan was to monitor for weight and follow up as needed. During the survey period from 12/03/2025 to 12/10/2025, the Certified Nurse Aide documentation record for eating had 13 out of 24 meals left blank (the resident's intake was not documented). During an observation and interview on 12/04/2025 at 1:55 PM, Resident #1 was in their bed after lunch and stated they did not eat the food, they ordered take out because they did not like the food at the facility. During an interview on 12/08/2025 at 11:01 AM, the Registered Dietitian reported there were no documented food preferences in meal tracker for Resident #1. They were a picky eater and ordered take out of what they preferred. During an interview on 12/09/2025 at 1:24 PM, the Registered Dietitian stated if a resident's wound was not healing, they would add a protein supplement. The wound team sends a weekly report that can be reviewed for interventions and the nutrition care plan would reflect any new additions. During an interview on 12/10/2025 at 10:22 AM Licensed Practical Nurse #9 stated Resident #1 did not like the taste of food the facility provides but would eat it at times. Resident #1 had been offered supplements in the past but refused to consume. 2) Resident #3 had diagnoses including Chronic Obstructive Pulmonary Disease, Acute Respiratory Failure with hypoxia, and diabetes. The 11/03/2025 Minimum Data Set Assessment documented Resident #3 had severe cognitive impairment and required supervision with eating. The Care Plan dated 06/24/2025 titled, Nutrition Status documented Resident #3 will eat at least 75% of meal as the goal. Interventions included food preferences, offer between meal nourishment/supplement. The care plan did not document a specific nutrition supplement. Resident #3's weight record documented on 10/07/2025 they weighed 152.4 pounds and on 11/25/2025 they weighed 137.4 pounds. The 11/21/2025 Dietary progress note documented most meals consumed were 50% intake and a weight loss of 6# in one (1) week with a recommendation to add Magic cup daily. The 11/23/2025 Physician order documented a no added salt, chopped texture diet. The 11/23/2025 Medical note documented the diet consult indicating mild weight loss due to decreased intake and to order Magic cup daily to prevent further weight loss. A physician order dated 11/28/2025 documented Magic Cup at 10 AM daily. During the survey period from 12/03/2025 to 12/10/2025, the Certified Nurse Aide documentation record for eating documented for 16 out of 24 meals the resident's intake was less than 50% intake. During an</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on observation, record review and interviews, conducted during the Recertification and Abbreviated surveys (2622355, 2622747) the facility did not ensure that sufficient staff was available to meet the needs of all residents. Specifically, actual staffing levels were below facility assessment desired levels on eleven of ninety shifts as documented on the daily staffing sheets. Residents remained in bed and did not receive showers as planned (See F677) and were not available for activities (See F679). Interviews with staff, residents and family members reported low staffing and care not being completed.</p> <p>The findings include:</p> <p>A Policy and Procedure titled Staffing last revised 10/25/2025 documented it is the facility policy to provide appropriate staff in the Nursing Department to promote the highest practicable levels of function and care for all residents of the facility.</p> <p>The Facility Assessment last reviewed in August 2025 documented the desired staffing for was 13 certified nurse aides for the 7 AM- 3 PM and 3 PM-11 PM shift, and six (6) certified nurse aides for the 11 PM- 7 AM shift. Desired staffing for nurses was six (6) nurses on 7AM-3PM and 3PM-11PM and 3 nurses on the 11PM-7AM shift.</p> <p>A review of the Daily Staffing Sheets from 11/1/2025-11/30/2025 documented on:</p> <ul style="list-style-type: none"> <li>- 11/1/2025, two (2) Certified Nurse Aides worked the 11 PM&amp;ndash;7 AM shift.</li> <li>- 11/2/2025, six (6) Certified Nurse Aides worked the 3 PM&amp;ndash;11 PM shift, and eight (8) worked the 7 AM to 3 PM shift.</li> <li>- 11/8/2025, four (4) Nurses worked the 7 AM&amp;ndash;3 PM and 3 PM&amp;ndash;11 PM shifts.</li> <li>- 11/10/2025, four (4) Certified Nurse Aides worked the 11 PM&amp;ndash;7 AM shift.</li> <li>- 11/15/2025, eight (8) Certified Nurse Aides worked the 3 PM&amp;ndash;11 PM shift.</li> <li>- 11/16/2025, eight (8) Certified Nurse Aides worked. the 7 AM&amp;ndash;3 PM shift.</li> <li>- 11/26/2025, two (2) Nurses worked the 11 PM&amp;ndash;7 AM shift.</li> <li>- 11/28/2025, eight (8) Certified Nurse Aides worked the 3 PM&amp;ndash;11 PM shift.</li> <li>- 11/29/2025, eight (8) Certified Nurse Aides worked the 3 PM&amp;ndash;11 PM shift.</li> </ul> <p>During an interview on 12/03/2025 at 10:44 AM Resident #6 stated they had not had a shower in a few weeks and did not get them twice a week because of bad staffing. They stated staff rush to change residents at night then the nurses and aides hang out at the desk. They stated they needed to be transferred by mechanical lift and that was extra work for the certified nurse aides.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a second interview on 12/04/2025 at 10:31 AM, Resident #6 was in bed and stated they did not get a shower yesterday (Wednesday) and was told they (staff) were too busy. Resident #6 stated no one offered to do it today and it looked like they would be staying in bed again today because of short staffing.</p> <p>During an interview on 12/03/2025 at 12:38 PM Resident #81 stated they sometimes had to wait 30 minutes to two (2) hours for aides to help them on the evening and overnight shift.</p> <p>During an interview on 12/04/2025 at 9:22 AM Certified Nurse Aide #6 stated on the weekends they were short staffed. They stated when they had four (4) certified nurse aides, one needed to supervise the day room, leaving only three (3) certified nurse aides to provide resident care for 40 residents. They stated they frequently worked without getting any breaks.</p> <p>During an interview on 12/04/2025 at 9:59 AM, Resident #4 stated the facility was short staffed, especially on the evening and night shift.</p> <p>During an interview on 12/04/2025 at 1:19 PM, a resident's family member stated on the weekends Resident # 73 had been left in bed all weekend due to short staffing.</p> <p>During an interview on 12/05/2025 at 1:33 PM, the Administrator stated had been at the facility for a month and were still adjusting. They had asked about staffing and were unaware that staffing was below the desired level at times. They stated they reviewed staffing daily. They encouraged the staffing coordinator or nursing supervisor to reach out to staff.</p> <p>During an interview on 12/05/2025 at 1:36 PM the Human Resource Director stated they were aware every other weekend was short staffed. They reviewed the shifts identified as being below the desired staffing levels and stated the daily staffing sheets were accurate and they were below the desired staffing levels.</p> <p>During an interview on 12/08/2025 at 10:35 AM, Certified Nurse Aide #7 stated staffing could be better, and Fridays were the worst days for staffing. The fewer certified nurse aides working means they had more residents on their assignment. They stated had to cover the Bistro (dining room on the lower level) and it took them away from the residents on the floor and resulted the residents on the floor waiting for assistance.</p> <p>During an interview on 12/08/2025 at 10:55 AM, Registered Nurse Supervisor #1 stated some days were staffed better than others and weekends could be short. They stated they worked as a team and thought all the care got done but sometimes a resident's preference for shower times or days did not get met.</p> <p>[10 NYCRR 415.13(a)(1) (i-iii)]</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on observations record review and interviews on recertification and abbreviated surveys (2670229) from 12/3/25 to 12/11/25 the facility did not ensure drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled. Specifically, 37 nurse signatures of 624 opportunities over 104 days were missing from the change of shift narcotic count log from 8/5/25 to 11/17/25. The facility policy for Narcotic Counting and Control dated 3/8/24 documented a complete count of all narcotics present on a nursing assignment, shall take place at any change of personnel which results in exchange of keys and change of responsibility for narcotic supply. This may occur at traditional shift change, or a mid-shift personnel change. The narcotic sheets are to be counted and logged with every count as part of the correct and accurate narcotic count procedure. Signature indicates agreement with accuracy of the sheet count as well as medications. Upon completion of the correct narcotic count, the keys are transferred to the oncoming nurse. The shift change signature sheet is signed by both nurses only upon completion of the correct count. All nurses are reminded that signing of the shift change signature sheet indicates acceptance of responsibility for the narcotic supply that is managed by those keys. Narcotic count sheets were reviewed from 08/05/25 to 11/17/25. There were 37 missing signatures of 104 days reviewed indicating the narcotic count was not completed before acquiring the narcotic keys. There were no medication count discrepancies. During an observation on the second floor on 12/05/2025 at 3:12 PM of the change of shift narcotic count between day Licensed Practical Nurse #25 and evening Registered Nurse #29 the count was completed including a count of how many blister packs. The controlled medications were counted and the oncoming an off going nurses signed the sheets. During an interview on 12/09/2025 at 12:57 PM Licensed Practical Nurse #18 stated the narcotic count was performed between the oncoming and off going nurses to ensure the controlled drugs count was correct. They stated they could not leave their shift until the count was completed and did not know why there were blanks and no signatures. During an interview on 12/4/25 at 10:04 AM the Director of Nursing stated they were informed there were missing signatures on the Narcotic count sheets. They went back and did a recount of the narcotics and found the count numbers were correct, but the signatures were not there to prove reconciliation took place. They did a whole house nurse education to stress the importance to ensure the count was completed and signed for. The unit nurses know they are supposed to perform an accurate narcotic count and document their signatures at the end of the count at the passing of the narcotic keys to the next shift. They stated the nurses left signature spots blank because they either forgot or they were rushing and busy or had to get back to the floor. Regardless of what the nurses said it has to be done, and a signature proves the count and exchange of keys was done. The Director of Nursing provided documentation of in-service education and training which was completed in November 2025 for all nurses regarding the Narcotic Count at the change of shift in reference to these discrepancies. It was determined the deficient practice was corrected and is cited as past non-compliance. 415.18(b)(1)(2)(3)</p>		

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  12/10/2025
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</p>

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  12/10/2025
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observations, interviews, and record review conducted during the Recertification and Abbreviated Surveys (2610401) from 12/3/2025 to 12/10/2025, the facility did not ensure that residents were free from significant medication errors one (1) of three (3) residents (Resident #98) reviewed for medications. Specifically, Resident #98 had a physician order for Lamictal (anti-seizure medication), five (5) doses were missed, the physician was not notified, and Resident #98 experienced a breakthrough seizure. The finding include:The policy and Procedure titled Medication Administration last revised 9/20/2024 documented all medication administration issues are identified and reported to the unit manager, charge nurse, or supervisor before the end of the shift. Medication-related and operational concerns including but not limited to labeling errors, unavailable medications, shortages, low inventory, discrepancies in controlled substance counts. These issues are addressed and corrected in accordance with applicable organizational policies and procedures.Resident #98 had diagnoses including epilepsy (brain disorder that causes repeated seizures), dementia, and headaches.The admission Minimum Data Set (MDS) (a resident assessment tool) dated 9/5/2025 documented Resident #98 had severe cognitive impairment, a seizure disorder, and was receiving an anticonvulsant medication.The comprehensive care plan titled Seizure Disorder, dated 9/2/2025, documented that the resident had a diagnosis of seizure disorder and directed staff to monitor drug treatment and adjust dosage as needed to minimize adverse reactions or interactions with other medications.The physician's order dated 9/2/2025 documented Lamictal 100 milligrams, 1 tablet by mouth two (2) times a day. The September 2025 Medication Administration Record (MAR) documented on 9/3/2025 Lamictal was signed as administered at 8 AM and 5 PM by Licensed Practical Nurse #12. On 9/4/2025 Lamictal was signed as held per physician order at 8 AM by Licensed Practical Nurse #8, and signed as given at 5 PM by Licensed Practical Nurse #11. On 9/5/2025 Lamictal was signed as held per physician order at 8 AM and 5 PM by Licensed Practical Nurse #8.Registered Nurse Supervisor #1's progress note dated 9/5/2025 at 5:50PM documented they were called to the resident's room by a family member who reported Resident#98 had experienced a seizure. The nurse practitioner was notified, and the resident was transferred to the hospital.Discharge Summary from the hospital dated 9/6/2025 documented the clinical impression was seizure activity. Laboratory results indicated a phenytoin level below the therapeutic range. Discharge instructions included follow-up with neurology and the primary care physician.The nurse practitioner's note dated 09/07/2025 documented the resident was seen for a follow-up visit status post emergency room visit for seizure. The facility 5-day investigation, submitted to the New York State Department of Health completed 09/09/2025, documented Lamictal was not given by Licensed Practical Nurse #12 (responsible for doses on 09/03/2025). The investigation did not address the doses held per physician order for a total of 5 missed doses.During an interview with the resident's family member 12/5/2025 at 11:24 AM, they stated that in early September Resident # 98 had a seizure slid out of bed. They rang the call bell, and staff responded and transferred to the hospital. During an interview on 12/8/2025 at 1:25 PM, Licensed Practical Nurse #12 stated they signed for giving Lamictal on the Medication Administration Record, however it was not given on 09/03/2025 at 8 AM and 5 PM because it was not available. They stated they called the pharmacy but did not notify the physician or the supervisor.During an interview on 12/8/2025 at 1:37 PM, Licensed Practical Nurse #11 stated they gave Resident #98 the Lamictal on 9/4/2025 at 5:00 PM, the medication was delivered from the pharmacy.During an interview on 12/8/2025 at 2:00 PM, Licensed Practical Nurse #8 stated the Lamictal was not given on 9/4/2025 at 8:00 AM and 9/5/2025 at 8:00 AM and 5:00 PM. They stated the medication was not available, they called the pharmacy, but they did not notify the physician or the nursing supervisor. During an interview with the pharmacist on 12/8/2025 at 8:50 AM, they stated that Lamictal was delivered on 9/3/2025 at 12:35 AM. They stated only 4 pills were delivered because there were questions regarding the interaction with the phenytoin (another anti-seizure medication). The pharmacist stated the order was received after 6 PM on the previous day, and the last scheduled delivery was at 10 PM; therefore, the medication was included in the next delivery at 12:35 AM.During an interview on 12/8/2025 at 3:15 PM, Registered Nurse Supervisor #1 stated they spoke with the pharmacist and was told the medication was not sent because they had questions regarding interaction with phenytoin. During an interview on 12/9/2025 at 11:44 AM, the Medical Director stated the resident experienced a breakthrough seizure. The Medical Director stated they did not think the missed doses caused the seizure. 10NYCRR415.12(M)(2)</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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation and interview conducted during the recertification survey from 12/03/2025 to 12/10/2025, the facility did not ensure food was distributed and served in accordance with professional standards for food service safety. Specifically, unlabeled and undated food items were observed in the kitchen and unit pantry, and expired food was observed in kitchen storage pantry and unit pantry. The findings include: The policy titled Food Storage dated 12/11/2025 documented the policy establishes comprehensive guidelines for the proper storage of food items in our facility to ensure food safety, prevent foodborne illness, maintain nutritional quality, and comply with federal and state regulations. We are committed to providing safe, wholesome meals to our residents while minimizing food waste and maintaining cost-effective operations. During the initial tour of the kitchen conducted on 12/03/2025 at 9:25 AM, in the walk-in refrigerator, a jar of chopped garlic and a container of ricotta cheese were open and undated, and a defrosted turkey breast wrapped in plastic and dated 11/26/2025 was observed. In the walk-in freezer an open undated plastic bag of perogies was observed. In the dry storage area, a large unopened container of salad dressing was observed with an expiration date of 08/25/2025. During an observation on 12/03/2025 at 10:30 AM, the first-floor refrigerator in the day room was observed with two (2) open undated bottles of ranch salad dressing and 2 undated bottles of French salad dressing. The first-floor pantry was observed with expired cookies. During an observation of the Unit 1 pantry on 12/03/2025 at 10:45AM, blueberry yogurt dated 11/3/2025 and vanilla yogurt dated 11/13/2025 was observed. An unlabeled open vanilla pudding with mold and a small [NAME] jar, unlabeled/undated, with an unknown substance were also observed. During an interview on 12/03/2025 at 10:53 AM, the Maintenance Director stated dietary was responsible for cleaning the refrigerator and restock snacks. They were unaware the cabinets in the day room were being used to store snacks. During an observation on 12/03/2025 at 11:00AM of the second-floor pantry, there was open and undated beverages including honey thick lemon water, nectar thick orange juice and a small milk container. During an interview on 12/03/2025 at 12:30 PM, Certified Nurse Aide #14 stated dietary was responsible for cleaning out the refrigerator, nursing staff should have labeled and dated any food they put in the refrigerator. During an interview on 12/08/2025 at 12:13 PM the Director of Nursing stated the dietary department was responsible to ensure the pantry refrigerators had no undated or expired foods. The nurses should have been dating the juices and thickened water when they open them for medication pass. They were unsure who was responsible for discarding the liquids for medication pass if they were past the 3 days or undated. During an interview on 12/08/2025 at 12:23 PM the Food Service Director stated the dietary staff were responsible to ensure all food items were labeled with date after opened. They did check to ensure that everything was dated, and any expired food was discarded and might have missed some items. The dietary staff did not stock the cabinets on the first-floor day room, and they were not sure who did. The dietary staff was responsible to check the pantry refrigerators to ensure all food was labeled and discarded if it was more than 3 days old. They were unaware how the expired cookies ended up in the cabinets in the day room. They further stated they or their staff were responsible to ensure all food in the kitchen was properly labeled and discarded after 3 days. They also stated any open food in the freezer should have had a date on it. During an interview on 12/09/2025 at 1:33 PM, the Administrator stated the Food Service Director was responsible to ensure all food was labeled and dated. 10 NYCRR 415.14(h)</p>		