

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 12/22/2024
NAME OF PROVIDER OR SUPPLIER Campbell Hall Rehabilitation Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 23 Kiernan Rd Campbell Hall, NY 10916	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0561</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 and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44673</p> <p>Based on observation, record review, and interview conducted during the Recertification, Abbreviated (NY00359302) and Extended Survey from 12/15/24 - 12/22/24, the facility did not ensure residents had a right to make choices regarding aspects of their life for 5 of 6 residents reviewed for smoking. Specifically, the facility did not offer a designated smoking area and did not offer a smoking cessation program prior to and after the facility changed its policy to prohibit smoking for Resident # 6, #9, #29, #41, and #54 who were known smokers at the time of admission.</p> <p>The findings are:</p> <p>The Policy and Procedure titled Smoking revised on 1/21/22 documented the facility aimed to maintain the highest quality of life for each resident who smoked, and smoking was permitted only in designated areas and at scheduled times.</p> <p>The Policy and Procedure titled Smoking created 6/23/22 documented the facility was to maintain the highest quality of life for each resident, and smoking will not be permitted by residents.</p> <p>During observation on 12/15/24 at 1:15 PM patio doors were marked with No Smoking signs.</p> <p>1. Resident #29 was admitted to the facility on [DATE] with diagnosis including Schizophrenia (serious mental illness) Diabetes and Anxiety.</p> <p>The 10/14/24 Quarterly Minimum Data Set (assessment tool) documented Resident #29 was cognitively intact.</p> <p>There was no documented evidence in Resident #29's electronic medical record that a smoking assessment to identify smoking habits, smoking cessation counseling, nicotine replacement options, and staff training in regards to smoking cessation programs had been offered when the facility changed its policy to prohibit smoking.</p> <p>During an interview on 12/15/2024 at 4:20 PM Resident #29 stated smoking was permitted when they were admitted to the facility, but later they had been made aware, smoking at the facility was no longer allowed.</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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Resident #41 was admitted to the facility on [DATE] with diagnoses including Paraplegia, (total loss of movements and sensation in the lower body) Borderline Personality Disorder (a mental disorder) and Schizophrenia.</p> <p>The Quarterly Minimum Data Set (assessment tool) dated 4/19/24, documented Resident #41 was cognitively intact.</p> <p>There was no documented evidence in Resident #41's electronic medical record that smoking cessation counseling, nicotine replacement options, and staff training in regards to smoking cessation programs had been offered when the facility changed its policy to prohibit smoking.</p> <p>During an interview on 12/15/24 at 1:11 PM Resident # 41 stated they were admitted to the facility in 2021. Resident #41 stated smoking was permitted at the time of admission, but the facility policy subsequently changed to a non-smoking facility. Resident #41 stated no accommodations were made for smokers, and smoking privileges were revoked.</p> <p>3. Resident #54 was admitted to the facility on [DATE] with diagnoses including Quadriplegia and Major depressive Disorder.</p> <p>The 9/24/24 Quarterly Minimum Data Set (assessment tool) documented Resident #54 was cognitively intact.</p> <p>The Comprehensive Care Plan titled non-compliance last updated 5/22/24 documented educate resident on smoking, monitor resident for smoking regularly and upon return from leave of absence for signs of smoking. Any issues were to be reported to the supervisor immediately, and smoking cessation support was to be offered.</p> <p>The Comprehensive Care Plan Titled Smoking last updated 10/1/24 documented Resident is a known smoker, including smoking marijuana. The care plan instructed staff to check the resident's clothing regularly and upon return from leave of absence for evidence of unsafe smoking practice. The smoking policy was to be reviewed with the resident and family upon admission and as necessary. Smoking cessation support was to be offered.</p> <p>There was no documented evidence in Resident #54's electronic medical record that smoking cessation counseling, nicotine replacement options, and staff training in regards to smoking cessation programs had been offered when the facility changed its policy to prohibit smoking.</p> <p>During an interview on 12/15/2024 at 2:00 PM the Administrator stated when the facility went from a smoking facility to a non- smoking facility the needs and preferences of residents who previously smoked were not considered.</p> <p>10 NYCRR 415.5(f)(2)</p>		

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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>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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45986</p> <p>Based on observation, record review and interview during the Recertification Survey from 12/15/24-12/22/24, the facility did not ensure that the building was maintained in good repair to provide a safe, healthy, functional, sanitary, and comfortable environment for residents, personnel, and the public.</p> <p>The findings are:</p> <p>On December 17, 2024, during the recertification survey, between 11:30 AM - 5:45 PM, the following was observed:</p> <ul style="list-style-type: none"> -The soiled room on the second floor, was observed with a dusty fan. - Resident's room [ROOM NUMBER], the tub was observed with a brown stain around the drain, and a green colored substance around the sink faucet. -Stained ceiling tiles on the second floor corridor. -The toilets in the nurse stations on the first and second floor observed with nonfunctional fans. - Resident's room [ROOM NUMBER], the toilet was observed with a dusty fan. - In the service corridor, on the second floor, the janitor's room door did not close properly. <p>The Director of Maintenance, who was present at the time of observations, stated that they will clean and fix the issues.</p> <p>NYCRR Title 10 - 415.15</p> <p>10 NYCRR, 711.2(a)(1)</p>

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44673</p> <p>Based on record review and interview during the recertification survey from 12/15/24-12/22/24, the facility did not ensure residents or resident's representatives were notified in writing of the facility policy for bed hold for 2 of 2 residents reviewed (Resident #49 and Resident #93) for hospitalization . Specifically, Residents #49 and #93 were transferred to the hospital, and the facility was unable to provide evidence that written notice of the facility policy for bed hold was given to the resident or the resident's representative.</p> <p>The findings are:</p> <p>The facility policy titled Bed Hold Reservation revised 6/2019 and documented that it is the policy of the facility to notify private insurance carrier that resident has been transferred to the hospital or is out on therapeutic leave.</p> <p>1. Resident #49 was admitted to the facility with diagnoses including Sepsis, Dementia, and Bipolar Disorder.</p> <p>The Minimum Data Set (assessment tool) discharge assessment dated [DATE] documented Resident #49 was discharged to hospital on 9/27/24.</p> <p>A Nursing Progress Note dated 9/27/24 documented Resident #49 was sent to the hospital for evaluation.</p> <p>A Nursing Progress Note dated 9/28/24 documented Resident #49 was admitted to the hospital with a diagnosis of Septic Shock.</p> <p>2. Resident #93 was admitted to the facility with diagnoses of Non Alzheimer's Dementia (brain disorder affecting memory and), Huntington's Disease, and Parkinson's Disease.</p> <p>The Annual Minimum Data Set (an assessment tool) dated 11/18/24 for Resident #93 documented severe cognitive impairment.</p> <p>The Nursing Progress Note dates of most recent hospitalization s included 12/4-12/5/24, and 11/29/24-12/2/24.</p> <p>When requested on 12/22/24 at 9:30 AM documentation could not be provided to verify that the facility notified Resident #49 and Resident #93 or the representative in writing about the facility bed hold policy for the hospital admission on 9/28/24.</p> <p>During an interview on 12/22/24 at 2:00 PM the Director of Social Work, stated notification of the facility bed hold policy was not provided to the resident or the resident's representative.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/22/24 2:38 PM the Director of Nursing stated nursing and social work were responsible for giving the family the notice of discharge. They were unable to provide a copy of the notification.</p> <p>10NYCRR 415.3 (i)(3)(i)(a)</p> <p>51214</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>51214</p> <p>Based on observation, record review and interview conducted during the Recertification Survey from 12/15/24 to 12/22/24, the facility did not ensure a Preadmission Screen was completed for 1 of 22 residents reviewed. Specifically, for Resident #55, the facility did not ensure the Screen form (DOH-695) was completed.</p> <p>The findings are:</p> <p>The Facility Screen/PreAdmission Screening and Resident Review Policy dated 5/26/2022 documents that the Social Worker is designated as the facility's Qualified Screener and is responsible for the completion of the Screen/PreAdmission Screening and Resident Review as identified in the New York State Department of Health Regulations. Section 4 documents that no resident will be admitted to the Facility without a completed PreAdmission Screening and Resident Review. The document must be done to determine whether or not the resident requires the level of services provided by the Facility, or if the resident requires the level of services of an inpatient psychiatric hospital or institution for mental disease or requires an intermediate care facility to determine whether or not the resident requires active treatment for mental illness or mental retardation.</p> <p>Resident #55 had diagnoses including Non-Alzheimer's Dementia (brain disorder affecting memory and other intellectual function), Anxiety Disorder, and Schizophrenia (severe brain disorder).</p> <p>The Annual Minimum Data Set Assessment (an assessment tool) dated 4/19/24 documented severe cognitive impairment for Resident #55.</p> <p>The Quarterly Minimum Data Set Assessment (an assessment tool) dated 9/28/24 documented severe cognitive impairment for Resident #55.</p> <p>There was no documented evidence that a Screen (form DOH-695) was completed for Resident #55.</p> <p>During an interview on 12/19/24 at 3PM, the Director of Social Services stated they were unable to provide the Screen therefore they could not verify if it had been completed.</p> <p>NYCRR 415.11(a)(5)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47626</p> <p>Based on observation, record review, and interview during the recertification and extended survey conducted 12/15/2024-12/22/2024, the facility did not develop and implement a comprehensive person-centered care plan to meet the resident's medical, nursing mental and psychosocial needs for 4 of 8 residents (Resident #15, #84, #29, and #75) reviewed. Specifically, Resident #15's comprehensive care plans did not include Dementia Care, Psychotropic Drug Use, or a Diabetic care plan; 2) Resident #84's comprehensive care plans did not include an at risk for pressure ulcer care plan; 3) Resident #29's comprehensive care plans did not include a smoking care plan; 4) Resident #75's comprehensive care plans did not include respiratory/oxygen use care plan.</p> <p>Findings include:</p> <p>Review of the facility policy titled Comprehensive Care Plans last reviewed 9/23/24, documented that [NAME] Hall Rehabilitation Center is dedicated to providing personalized, high-quality care for our residents using a comprehensive resident assessment and care planning process. This process is designed to maximize and maintain each resident's functional potential and quality of life. A Comprehensive Care Plan (CCP) is crucial to achieving this, and we are committed to developing a CCP for each resident by the 21st day of admission, updated quarterly, annually, upon readmission, and with any significant change of condition.</p> <p>1. Resident # 15 was admitted with diagnoses including Left Cerebrum traumatic, Diabetes and Alzheimer's.</p> <p>A Quarterly Minimum Data Set (an assessment tool) dated 10/02/24 documented the resident was moderately impaired for decision making, required set up assistance for eating and partial to moderate assistance for other activities of daily living. Resident #15 had documented behaviors 1-3 days in the look back period of physical behaviors directed at others. The resident received antipsychotic, antianxiety, and hypoglycemic agents in the 7 days look back period.</p> <p>A review of the physician orders dated 11/25/24 documented the following medications: Lorazepam 0.5mg 3x daily, Seroquel 12.5mg 2 times daily, and Insulin.) how often)</p> <p>A review of Resident #15's Care Plans revealed the Dementia, Diabetes, and Psychotropic Drug care plans were fully developed with no goals or interventions documented.</p> <p>During an Interview on 12/19/24 12:09 PM with the Staff #2 Registered Nursing Supervisor they stated the nurse should have developed a plan of care to include goals and interventions. They do not know why these care plans were not completed.</p> <p>During an Interview on 12/19/24 12:28 PM with Staff #12 Licensed Practical Nurse stated we know which residents have dementia by their diagnosis list. There should be a Dementia or impaired cognition care plan for residents with dementia or Alzheimer's.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. Resident #84 was admitted with diagnoses including Dementia, Hip Fracture, and respiratory failure</p> <p>During an observation on 12/18/24 07:03 PM the resident was noted in bed, the resident's feet were not off loaded, bilateral heels intact, no unhealed pressure ulcers.(you observed all unhealed pressure ulcers?)</p> <p>The 5-day Minimum Data Set (an assessment tool) dated 6/29/24 documented, the resident was moderately impaired for decision making. The resident required substantial to maximal assist with all activities of daily living. The skin assessment documented the resident was at risk for developing pressure ulcers had a surgical wound, but no unhealed pressure ulcers.</p> <p>A review of the Braden Score dated 9/2/24 (score to assess the resident's risk for developing pressure ulcers) documented the resident was at risk for developing pressure ulcers.</p> <p>A review of the physician orders dated 6/26/24 documented weekly skin checks on bathing days.</p> <p>A review of the Care Plans noted there was no at risk for pressure ulcer care plan from readmission in June 2024 to present with physician orders for weekly skin checks.</p> <p>During an interview on 12/19/24 10:03 AM with the Director of Nursing they stated the resident had an at risk for skin breakdown care plan, which was last reviewed in June. When the resident returned from the hospital the care plan was not reactivated. They do not know why and could not explain why it was not initiated in September with the last Minimum Data Set Assessment.</p> <p>During an interview with Staff #2 Registered Nursing Supervisor on 12/19/24 at 11:38 AM, they stated care plans are developed by the Registered Nurse. When a resident goes out to the hospital and they return, the care plans need to be reviewed and reinstated. As part of the readmission assessment the Registered Nurse should review the medications, do a Nursing assessment and review, and revise the Plan of Cares.</p> <p>During an interview with the Director of Rehabilitation on 12/20/24 03:34 PM stated we would put in a care plan in for potential for skin breakdown as an IDT, not sure if a care plan was put in place. The care plan should have included turning and positioning as well as off-loading heels.</p> <p>During an interview with the Nurse Practitioner # 1 on 12/20/24 04:44 PM, they stated the resident was at risk for developing pressure ulcers and protocols should have been put in place to off load their heels and turn and position every 2 hours. The Registered Nurse should have developed a care plan.</p> <p>3. Resident #29 was admitted to the facility with diagnoses including Schizophrenia (serious mental illness), Diabetes, and anxiety disorder.</p> <p>The 10/14/24 Quarterly Minimum Data Set (assessment tool) documented that Resident #29 demonstrated intact cognition and was dependent on staff for activities of daily living. The Resident utilizes a wheelchair for mobility.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation of the patio on 12/15/24 at 4:18 PM Resident #29 was observed on the patio and a strong odor of cigarette smoke was present. No staff members were observed providing supervision on the patio.</p> <p>During an observation on 12/16/24 at 1:15PM, with the Director of Maintenance, Residents #29 and #54 were observed smoking in the gazebo located on the patio without supervision. Resident # 29 stated that they discard the ashes in the snow.</p> <p>Review of the electronic health record revealed Resident #29 had no care plan for smoking or non-compliance and no smoking assessment.</p> <p>During an interview on 12/19/24 at 10:05 AM, the Registered Nurse Supervisor #1 stated that they were responsible for the initiation of Care Plans on admission as well as updates to interventions and when there is changes such as falls and new orders.</p> <p>During an interview on 12/19/24 at 10:14 AM, the Director of Nursing stated that routine updates of care plans were completed by nursing. They stated that the Registered Nurse Supervisors initiate the care plans on admission. Stated that the updates should be completed routinely and checked at care plan meetings.</p> <p>10NYCRR 415.11(c)(1)</p> <p>51214</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51214</p> <p>Based on observations, interviews, and record reviews conducted during the Recertification and Abbreviated (NY00361230) Surveys conducted from 12/15-12/22/24, the facility did not ensure that the Comprehensive Care Plans were revised for 4 of 14 residents (#41, #89, #48, and #34) reviewed for Care Planning. Specifically, 1) The Smoking Care Plan for Resident #41 was not revised to include interventions for safe smoking after resident caused a fire when they extinguished a cigarette in the leaves behind the gazebo on the facility patio; 2. The Respiratory Care Plan for Resident # 89 was not revised to reflect the intervention of the physician order for oxygen as needed. Furthermore, the Psychotropic Medication Care Plan for Resident #89 was not revised to include interventions or goals. 3. The Discharge Care Plan for Resident #48 was not updated to reflect the planned discharge of resident or the related goals or interventions; 4. The Psychotropic Medication Care Plan for Resident # 34 was not updated to reflect the discontinuation of psychotropic medications</p> <p>Findings include:</p> <p>The Facility Comprehensive Care Plan Policy last reviewed 9/23/24 documents that the development and review of the Comprehensive Care Plan will involve an interdisciplinary team. The attending physician will timely review the Comprehensive Care Plan alongside the Nurse Manager responsible for the resident's care. Residents Comprehensive Care Plan will be individualized and remain up to date, reflecting the resident's current status and needs. Any changes to the Comprehensive Care Plan by the relevant interdisciplinary team member(s). All Comprehensive Care Plans at a minimum will be reviewed and or updated quarterly.</p> <p>Resident #41 had diagnoses that included, but not limited to, Paraplegia, Schizoaffective Disorder and Borderline Personality Disorder.</p> <p>The Minimum Data Set (assessment tool) dated 10/18/24 documented moderately impaired cognition and no tobacco use.</p> <p>Comprehensive Care Plan dated 9/1/23, and a care plan review note dated 6/28/24, documented that resident smoked in his room. Interventions included to review smoking policy with resident and family on admission, readmission and as needed. Staff will continue to counsel resident on a daily basis to ensure the safety of smoking in the facility is complied. Resident has been referred to psychologist and psychiatrist due to his noncompliance with the facility policy of non-smoking, the resident will be educated and offered smoke cessation, visually observe residents clothing and surroundings regularly for signs of unsafe smoking including smoke, ashes and burns on hands and clothing.</p> <p>A nursing progress note dated 10/3/24 documented staff approached Resident #41 regarding the aroma and visible smoke emanating from the resident's room. The resident was reminded that the facility was smoke free and instructed not to smoke in the facility. The resident acknowledged awareness of the policy and stated that smoking would not occur indoors in the future.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A facility investigation dated 11/4/24, completed by the facility Administrator, documented on 11/1/24 around 4:15 PM, Resident #41 was smoking in the gazebo and put out a cigarette in the leaves behind the gazebo starting a fire. The root cause analysis determined Resident #41 was a smoker, frequently used the patio and put ashes on the gazebo and the ground surrounding it. The dry air and warm environment contributed to the cigarette butt lighting the dry leaves on fire. The immediate action was the patio was closed on the weekend and reopened Monday 11/4/24. The corrective action was that Resident #41's patio privileges were revoked until further notice.</p> <p>There was no documented evidence of any updates made to the smoking care plan after 6/28/24.</p> <p>2) Resident #89 had diagnoses that included, but not limited to, Unspecified Atrial Fibrillation (heart arrhythmia), Dyspnea (difficulty breathing), and Chronic Obstructive Pulmonary Disease (lung disease that affects oxygen intake and breathing).</p> <p>Physician Orders dated 8/22/24 documented to administer Oxygen at 2 liters via nasal cannula for oxygen saturation below 90% as needed.</p> <p>The Comprehensive Care Plan for Resident #89 documented a Focus of Respiratory Disorders-Shortness of Breath dated 8/26/24. There were no related diagnoses listed. There were no interventions or goals documented on the care plan including oxygen use.</p> <p>The Annual Minimum Data Set (an assessment) dated 12/4/24 had no documentation of oxygen therapy.</p> <p>Observations:</p> <p>During an observation on 12/17/24 at 07:59 AM, Resident #89 was observed with Oxygen 3 liters in use via nasal cannula, no respiratory distress noted.</p> <p>During an observation on 12/18/24 at 08:39 AM, Resident #89 was observed with Oxygen 3 liters in use via nasal cannula, no respiratory distress noted.</p> <p>During an observation on 12/19/24 at 11:52 AM, Resident #89 was observed with Oxygen 3 liters in use via nasal cannula, no respiratory distress noted.</p> <p>During an interview on 12/19/24 at 09:29 AM, Unit Manager #1 reviewed and confirmed that Resident #89's order for Oxygen was 2 liters as needed for oxygen saturation below 90%. In response to no specific care plan present for oxygen use, they stated that they do not complete the initial care plans. They stated they add to them but do not initiate or develop the care plans.</p> <p>In addition, Resident #89 had no interventions or goals related to monitoring behavior or the effectiveness/response to gradual dose reductions of psychotropic medications on their Psychotropic Medication Care Plan.</p> <p>The Annual Minimum Data Set (an assessment tool) dated 12/6/24 documented the resident had severely impaired cognition, with diagnoses including Antipsychotic, Antianxiety, Antidepressant, and Anticonvulsant use.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident # 89's Physician order documented dated 8/22/24 documented Resident #89 was receiving Remeron 15mg give one tablet orally once daily for depression. The Physician order dated 12/5/24 documented Lorazepam 0.5mg orally twice daily. The Physician order dated 12/9/24 documented Seroquel 25mg give one tablet orally daily.</p> <p>Psychiatric Nurse Practitioner progress note dated 12/9/24 documented a Gradual Dose Reduction.</p> <p>Psychiatric Nurse Practitioner progress note dated 12/11/24 documented resident energy level and discontinuation of Seroquel. Psychiatric Nurse Practitioner progress note dated 12/18/24 documented review of medications with no side effects noted and other medication changes.</p> <p>Resident #89's Comprehensive Care Plan dated 12/7/24 had no documented interventions or goals listed on the use of psychotropic drugs.</p> <p>During an interview on 12/19/24 at 10:00 AM, the Staff Educator stated that they provide the education to the staff on care planning. They stated that the Registered Nurse is supposed to initiate the care plans and the Licensed Practical Nurses or Registered Nurses can update the interventions on the care plans. Incidents, new focus and changes in the residents are communicated to the Registered Nurse Supervisor or other Registered Nurses in facility so that the care plans can be updated.</p> <p>During an interview on 12/19/24 at 10:05 AM, Registered Nurse Supervisor #1 stated that the Registered Nurse Supervisors are responsible for the initiation of Care Plans on admission and for updates to interventions if something changes when they are on duty. They stated that they believe the Minimum Data Set Registered Nurse also updates care plans on a regular basis.</p> <p>During an interview on 12/19/24 at 10:14AM, the Director of Nursing stated that routine updates of care plans are completed by nursing. The Director of Nursing stated it is a joint effort from all nurses right now. The process would be for the Unit Managers to check the care plans routinely. Presently they only have one Unit Manager. If the Unit Manager is a Licensed Practical Nurse, and a focus needs to be added, they would be expected to notify a facility Registered Nurse. Stated that the Registered Nurse Supervisors do initiate care plans on admission and updates should be completed routinely and checked at care plan meetings.</p> <p>3)Resident #48 had diagnoses that included, but not limited to Unspecified Dementia, Pain, and Generalized Anxiety Disorder.</p> <p>The Admission Minimum Data Set (an assessment tool) dated 6/12/24 documented no behaviors and dependent on staff for hygiene, bathing, dressing, required maximum assistance with transfers. Overall goal for discharge unknown.</p> <p>The Comprehensive Care Plan for Resident #48 dated 6/7/2024 documented on a Discharge Care Plan that resident was a Long Term Care resident. Resident #48 was discharged home on 11/27/24.</p> <p>There were no documented nursing progress notes, social works notes or goals of a discharge to the community after admission on 6/7/2024</p> <p>Nurse Practitioner Medical progress note dated 11/25/24 documented no discharge anticipated at this time.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Physician note dated 11/27/24 had documented resident was discharged on [DATE] with recommendation to follow up and with Primary Care Physician for medication review and continuation of medical management and preventative care in 3-7days. There was no other physician note for discharge prior to the physician note on 11/27/24. There was no physician discharge orders.</p> <p>Nursing progress notes had no documented evidence of notes related to discharge or discharge planning prior to discharge on 11/27/24.</p> <p>Social Services progress notes had no documented evidence of notes related to discharge or discharge planning prior to discharge on 11/27/24.</p> <p>During an interview on 12/19/24 at 01:08 PM, the resident's daughter stated that the resident was now home, like a new person, doing well, and has a private aide that cares for her.</p> <p>During an interview on 12/22/24 at 12:33PM, the Director of Nursing stated that the discharge planning was ongoing for Resident #48. Stated that the Home Care Certified Nursing Assistant and daughter were present at the time of discharge to review discharge instructions. The Director of Nursing stated that they were definitely working on the discharge prior to the resident leaving facility. The Director of Nursing did not provide an explanation why there was no documentation regarding discharge planning for Resident #48</p> <p>During an interview on 12/22/24 at 1:51PM, the Director of Social Services stated that the resident went home with Home Care Agency services in place. Discussed case, expressed knowledge regarding discharge, and stated they worked on the planning prior to resident going home. Acknowledged that there were no notes in the electronic medical record regarding discharge. Stated they were committed to doing better.</p> <p>10NYCRR 415.11(c)(2)(i-iii)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666</p> <p>Based on observation, record review, and interview during the recertification, abbreviated (NY00359302), and extended surveys from 12/15/2024 to 12/22/2024, the facility failed to provide adequate supervision to prevent accidents related to smoking for 6 of 6 residents (#2, #6, #9, #29, #41 and #54) identified as smokers. Specifically, Resident #41 was a known smoker in a non-smoking facility and the facility failed to complete safety assessments or develop and implement a plan of care to ensure their safety, when it was known that the resident continued to smoke outside of the facility. On 11/1/2024 a fire was started on the outside patio when Resident #41 threw a cigarette butt into dry leaves. There were no facility staff supervising the resident during this smoking activity. Facility staff was alerted to the fire when the Director of Human Resources observed the smoke and fire from their office window. Facility staff had to remove residents from the area and extinguish the fire. Additionally, 2) Resident #54 had cigarettes and lighters with a strong odor of cigarette smoke in their room; 3) Residents # 2, #29, #41, and #54 were observed smoking on the patio without supervision. The patio was observed with cigarette butts in raised flower planters; there were no ashtrays or cigarette receptacles on the patio. The facility was aware the residents continued smoking and did not complete safety assessments or provide supervision. This resulted in Substandard Quality of Care, with no actual harm, that was Immediate Jeopardy with the likelihood for serious adverse outcome to all 102 residents in the facility.</p> <p>Findings include:</p> <p>The facility Smoking Policy and Procedure dated 1/21/2022 documented residents could smoke, and the Nursing Supervisor would assess the residents' ability to smoke safely by completing a smoking assessment that included an evaluation of the resident safety awareness, judgement, cognitive ability, and manual dexterity. The policy listed designated times for smoking and supplies would be marked with the resident's name and kept in a locked drawer in the copy room.</p> <p>The facility Smoking Policy dated 6/23/2022 documented smoking would not be permitted by residents. The policy did not address how to accommodate the residents that were smoking prior to the policy change. The policy did not address resident smoking contracts, agreements or participation in smoking cessation programs.</p> <p>1) Resident #41 was admitted to the facility on [DATE] with diagnoses of Paraplegia (an impairment in motor or sensory function of the lower extremities), Schizoaffective and Borderline Personality disorder(Mental illness) . The Minimum Data Set (resident assessment tool) dated 10/18/2024 documented the resident had moderately impaired cognition and did not document tobacco use. Resident self ambulates by wheelchair.</p> <p>Resident #41's smoking assessment dated [DATE] documented the resident could only smoke while supervised. There were no further directions guiding the resident during smoking activity. There were no other smoking assessments in the resident's medical record.</p> <p>(continued on next page)</p>		

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

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

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

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

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>During an observation of the patio on 12/15/2024 at 4:18 PM, Residents #29 and #2 were outside the patio door on their way into the facility. A strong odor of cigarette smoke was present, no staff members were observed providing supervision on the patio. The residents were interviewed at the time and Resident #29 stated they were not smoking but Resident #2 was. Resident #2 was aphasic (a disorder that impairs the ability to communicate) but shook their head no. Resident #29 stated they were allowed to smoke when they were admitted to the facility and one day they were told they could no longer smoke at the facility.</p> <p>During an observation on 12/16/2024 at 1:15 PM, with the Director of Maintenance present, Residents #29 and #54 were observed smoking in the gazebo located on the patio without supervision. Resident #29 was interviewed at the time and stated that they discarded their ashes in the snow.</p> <p>During an observation on 12/17/2024 at 1:32 PM, Resident #6, Resident #29, and Resident #41 were observed smoking cigarettes on the patio without staff supervision.</p> <p>The facility was notified of the Immediate Jeopardy on 12/18/2024 at 4:39 PM. The Immediate Jeopardy was lifted on 12/21/2024 prior to the completion of the survey based on the following corrective actions:</p> <ol style="list-style-type: none"> 1. The Smoking Policy was reviewed and updated to include that residents admitted to the facility prior to the implementation of the nonsmoking policy would be given smoking privileges. These residents who desired to smoke would be permitted to do so if the facility Interdisciplinary Team determined that the practice was safe for the residents, and they do so in the facility designated area. 2. A nursing assessment by a Registered Nurse was done for all smokers. They examined the residents and clothing for any burns. This was completed this on 12/18/2024. 3. All residents that currently smoke were assessed to determine if they were safe to smoke or require supervision and or assistance. This was completed 12/18/2024. 4. Safe smoking contracts were established for residents that smoke. This was completed on 12/18/2024. 5. A safe smoking area 30 feet from the building was established on 12/18/2024. 6. Appropriate receptacle for cigarettes butts was installed. On 12/18/2024 the receptacle was ordered with a delivery date 12/23/2024. On 12/20/2024 a small metal step-on garbage can that self-closed was installed. Surveyors observed garbage can being utilized during smoking activity. Two residents (#29, #41) were observed smoking on the patio under staff supervision. Cigarettes were disposed of in the can under the supervision of the facility staff. On 12/21/2024 at 10:00 AM, Residents #54, #29, #2 and #41 were observed smoking on the patio in the designated area under staff supervision. The small metal step-on garbage can was in use. 7. Sign for supervised smoking area was posted on 12/18/2024. 8. Smoking aprons were placed by exit to patio for those residents assessed to need an apron. <p>(continued on next page)</p>		

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

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 12/21/2024 two smoking aprons were observed stored in two tier plastic storage bins by the [NAME] room door.</p> <p>9. A standard size all-purpose fire extinguisher was located near the patio door on 12/18/2024.</p> <p>10. Smoking materials for all residents were removed from resident rooms and placed in a locked medication cart, completed 12/18/24.</p> <p>11. Supervised smoking times were assigned for 10:00 AM, 2:00 PM and 6:30 PM; doors were locked when smoking was not in session, completed 12/18/2024.</p> <p>12. Schedule of staff supervision was completed 12/19/2024.</p> <p>13. Care plans for all 6 smokers were completed for safe smoking on 12/19/2024.</p> <p>14. Physician orders for each smoker documented residents were care planned to smoke in facility designated area only.</p> <p>15. The facility employs 109 staff members. Of these, 102 completed the in-service training, including supervisors. Dates of the in-service were 12/18/2024, 12/19/2024 and 12/20/2024. A sample of staff members from Nursing, Rehabilitation, Administration, and Recreation were interviewed and verified they received the education.</p> <p>16. All supervisor staff were educated on facility procedures particularly their role to call 911 in the event of a fire.</p> <p>17. An hourly smoking monitoring log was maintained to check resident rooms for signs of smoking.</p> <p>18. The patio door was locked and remained locked except during the smoking times. Staff was observed supervising the smokers, unlocking the door to allow the residents into the smoking area and locking the door when smoking was completed.</p> <p>10 NYCRR 415.5(f)(2)</p> <p>44673</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47626</p> <p>Based on observations, interviews, and record review conducted during the standard survey from 12/15/24-12/22/24, the facility did not ensure that residents who had an indwelling/ suprapubic (foley) catheter (tube inserted into the bladder to drain urine) received the appropriate care and services to manage catheters for one (Resident #86) of three residents reviewed for bowel and bladder. Specifically, Resident #86 had a size 16 French suprapubic catheter surgically inserted, the facility did not develop a care plan, obtain a doctor's order with diagnosis to include the catheter size or directions on care of the suprapubic tube or when the catheter should be changed.</p> <p>The finding is:</p> <p>Resident #86 had diagnoses of Chronic Obstructive Pulmonary Disease, Bipolar Disorder, and Hypertension.</p> <p>The Quarterly Minimum Data Set (an assessment tool) dated 9/27/24 documented the resident's cognition was intact. The resident required supervision to moderate assistance for activities of daily living. The resident has an indwelling catheter.</p> <p>During an observation on 12/17/24 at 2:00 PM the resident was in bed with a urinary catheter attached to a urinary drainage system.</p> <p>During an observation on 12/18/24 at 4:12 PM the resident was in bed and had a 16 French suprapubic catheter attached to a urinary drainage system.</p> <p>A review of the hospital record dated 9/23/24 documented the resident had an elective suprapubic tube placed for urinary incontinence without sensory awareness. A size 16 Foley suprapubic tube was inserted.</p> <p>A review of the Care Plan dated 9/24/24 documented the resident has an indwelling catheter for bladder elimination. The care plan did not include a diagnosis, catheter or balloon size for the suprapubic catheter.</p> <p>A review of the November 2024 and December 2024 physician orders documented an order to monitor urinary output every shift there were no orders for the care of the suprapubic catheter tube.</p> <p>A review of the Medication Administration Record and Treatment Administration Record for September 2024-current did not document the suprapubic tube was replaced.</p> <p>A review of the urology consult dated 10/31/24 documented the suprapubic tube was replaced with a 16 French catheter.</p> <p>A review of the nurses note dated 10/31/24 documented suprapubic tube was changed during an appointment with the urologist, a new 16 French catheter and bag were placed.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Urology consult dated 12/4/24 documented a 14 French tube inserted at [NAME] Hall was too small to drain well, a 16 French tube inserted.</p> <p>During an interview on 12/18/24 at 1:28 PM with the Director of Nursing stated we were unable to locate the current order for the suprapubic tube. We were aware the resident went out to urology recently because the suprapubic tube was not draining, and the urologist replaced the tube.</p> <p>During an interview on 12/18/24 at 2:31 PM with Resident #86 the doctor advised them to get the tube because they had to urinate every 30 minutes. They did not know what the diagnosis was or why they needed it. The facility changed it once after the surgery but does not remember what day or who changed it.</p> <p>During an interview with Licensed Practical Nurse #12 on 12/19/24 at 8:53 AM stated the resident has a suprapubic tube, the supra pubic tube should be changed per physician orders, they stated in reviewing the record an order for the suprapubic tube was placed on 12/18/24 and it did include the foley size but did not include a diagnosis or balloon size. They were unaware when it was changed in the facility.</p> <p>10NYCRR 415.12 (d) (2)</p>		

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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>Provide enough food/fluids to maintain a resident's health.</p> <p>51214</p> <p>Based on observations, interviews and record review during the recertification survey conducted from 12/15/24-12/22/24, the facility did not ensure that acceptable parameters of nutritional status for 1 of 2 residents (Residents #93) reviewed for Nutrition were maintained. Specifically, Resident #93 had a significant weight loss of 28.12% in four months (8/28/24-12/18/24) and that weight loss was not communicated to the physician effectively resulting in no assessment by the physician for weight loss.</p> <p>Findings included:</p> <p>The Facility Policy titled Weight Monitoring last reviewed 9/20/24 documents that Residents experiencing unplanned weight gains or losses will have such changes monitored and care plans revised, as necessary, by the Interdisciplinary Team. Furthermore, it documents that the Registered Dietician/Dietician Technician is responsible for documentation regarding significant weight changes as well as notification to the attending physician. Dietary is also responsible for documenting a progress note and reviewing and revising the Comprehensive Care Plan, as necessary. The physician is responsible for documenting a medical note and implementing appropriate medical interventions.</p> <p>Resident #93 had diagnoses including, but not limited to, Huntington's Disease, Parkinson's Disease, and Gastritis.</p> <p>Facility Clinical Monitoring Report documented a weight of 145.8 pounds on 8/28/24.</p> <p>Dietary progress note dated 8/28/24 documented Resident #93 noted with decreased appetite and oral intake of meals status post recent hospitalization . Significant weight loss of 23.5%. Recommendations were to consider a more aggressive bowel regimen and document all Bowel movements, recent labs (renal and hydration indices, electrolytes, Complete Blood Count), honor food preferences, continue current oral supplementation and adjust based on any observed preference.</p> <p>The Comprehensive Care Plan dated 10/25/24 documented a Focus of Dietary-Nutrition Risk related to inadequate oral intake (meals and fluids) related to variable appetite and psychiatric illness as evidenced by consuming less than 50% of many meals provided, status post intravenous hydration, Schizoaffective Disorder (serious mental illness).</p> <p>Goals included, but not limited to, resident will maintain adequate nutritional status as evidenced by least restrictive diet tolerated, no signs or symptoms of malnutrition, no significant change from current body weight.</p> <p>Interventions included, but not limited to, continue current diet consistency as tolerated, continue ensure order, encourage meals/fluids, assist as needed, encourage adequate hydration, and provide additional 240 milliliters of fluids every shift, monitor for need of softer diet.</p> <p>Facility Clinical Monitoring Report documented a weight of 122.2 pounds on 10/30/24.</p> <p>(continued on next page)</p>		

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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>The Annual Minimum Data Set (an assessment tool) dated 11/4/24 documented set up assistance for eating and oral hygiene, weight 131 pounds and height 68 inches, weight loss of 5% in the last month and 10% in the last 6 months, and not a physician prescribed weight loss. No oral or dental conditions documented. No special treatments indicated.</p> <p>Facility Clinical Monitoring Report documented a weight of 116.4 pounds on 11/29/24.</p> <p>Physician order dated 12/2/24 documented Vitamin E 268mg (400 unit) capsule take 1 capsule by oral route once daily.</p> <p>Dietary progress note dated 12/4/24 documented a significant weight loss of 32.4% in less than 180 days.</p> <p>Recommended interventions included, but not limited to, evaluate, and discontinue unnecessary medications to limit pill burden, discontinue Vitamin E, continue current diet, Ensure, and provide substitutes. No evidence of discussion of weight loss with Physician.</p> <p>There was no evidence of Dietary progress notes between 8/28/24 and 12/4/24.</p> <p>Physician order dated 12/4/24 documented House Diet, chopped consistency, thickened liquids-none, Special Instructions: Bland diet/chopped/thin.</p> <p>Physician order dated 12/4/24 Ensure Clear 8 oz Frequency three times a day or as desired, alternate with Ensure clear if one or the other declined.</p> <p>Physician order dated 12/4/24 Ensure Plus 8oz Frequency three times a day or as desired, alternate with ensure plus if one or the other is declined.</p> <p>During an observation on 12/17/24 at 8:25 AM, Resident #93 observed lying in bed, breakfast tray set up for them at bedside. Resident #93 not eating. At 8:39 AM, Resident #93 breakfast tray observed at bedside, little consumption noted, staff removing tray from bedside.</p> <p>During an observation on 12/18/24 at 8:36 AM, Resident #93 observed lying flat in bed, meal tray on bedside table, no staff assisting with feeding. At 9:46AM Resident #93 observed in bed, lying flat, breakfast tray remains on bedside table, small amount of food appears to have been eaten.</p> <p>During an observation on 12/18/24 at 12:24 PM, lunch tray set up for Resident #93 on bedside table. Resident #93 sitting at side of bed looking at tray, no staff assistance observed with feeding. Resident #93 then layed back down in bed. At 12:44 PM, observed Certified Nursing Assistant in room with Resident #93 assisting Resident #93 with fluid consumption. Verbal encouragement to eat also provided to Resident #93, however they stated, no don't want that.</p> <p>Facility Clinical Monitoring Report documented a weight of 104.8lbs on 12/18/24.</p> <p>(continued on next page)</p>		

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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>During an observation on 12/20/24 at 8:34 AM, Resident #93 observed sitting up in dining room in wheelchair, breakfast tray in front of them on table, no assistance or encouragement with eating observed. Resident #93 preparing tea independently, playing with straw, drinking fluids intermittently. At 8:50 AM, Resident #93 remains sitting at table with breakfast tray, not eating any of the food on tray, no assistance/encouragement observed by staff, drank some fluids with eyes half closed. At 9:01 AM while feeding another resident at table, Licensed Practical Nurse #7 provided verbal encouragement to Resident #93 to eat but resident did not consume any food.</p> <p>During an interview on 12/20/24 at 9:11 AM, Licensed Practical Nurse #7 stated that Resident #93 used to have a great appetite and eat everything, but not anymore and has lost a lot of weight.</p> <p>During an interview on 12/20/24 at 10:02 AM, Certified Nursing Assistant #15 stated that Resident #93 has been declining. Resident #93 requires set up assist with meals and does need verbal assistance/encouragement on occasion, refuses meals at times, but does like Ensure and will often drink that instead of the meal provided. Meal consumption and snacks are tracked in Sigma (electronic medical record). They stated they report meal refusals to the nurse. Uncertain how often Resident #93 is weighed. They stated Resident #93 has lost weight since they first came to the facility. Denies Resident #93 having any trouble swallowing or eating the current ordered diet.</p> <p>During an interview on 12/20/24 at 10:12 AM, Licensed Practical Nurse #16 stated that Resident #93 requires set up supervised assist for meals generally, but level of assistance varies day to day. Nursing monitors resident intake and tries to have them up in dining room for closer monitoring, but that depends on resident preference for the day. Stated they have noticed that Resident #93 has had a cognitive decline and weight loss since they started at the facility eight months ago. Stated they are uncertain of the frequency of the resident's weight monitoring, but they have a weight binder for the unit that would indicate the frequency. Stated that consumption is recorded by the Certified Nursing Assistants in the electronic medical record, and they report poor intake to the floor nurses. They encourage supplements if Resident #93 refuses a meal. If Resident #93 continues to refuse, they let the Registered Nurse Supervisor or Nurse Practitioner know. They contact the Dietician if there is a question about the resident's diet or texture. Stated that there has been no indication that Resident #93 is having difficulty swallowing and denies any indication of pain when they eat.</p> <p>Unit Weight book reviewed on 12/20/24 at 10:30AM, unable to locate Resident #93 on several weekly and monthly sheets in binder, unable to decipher the frequency of their weight monitoring. Certified Nurse Assistant #15 and Licensed Practical Nurse #16 reviewed the weight book and were unable to provide the frequency of weights for Resident #93. Licensed Practical Nurse #16 stated they are in the process of reorganizing the weight book for the unit.</p> <p>(continued on next page)</p>		

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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>During an interview on 12/20/24 at 11:03 AM, the Registered Dietician stated that all residents are weighed monthly on admission/or return from the hospital, and more frequently if indicated. There are no orders in the electronic medical record for weight monitoring frequency. They stated they have been working on improving the weight tracking process. They compile lists of residents on weekly weights on Monday and bring those lists to the units. They distribute lists to the units for monthly weights as well. Some residents are weighed by the rehabilitation department if they are on therapy. Resident #93 is currently on therapy and weighed weekly by the rehabilitation staff. Resident #93's weight loss has been significant since hospitalization several months ago. Risk factors include a BMI of 17.8 and gastric medical issues (stomach issues). Stated that Nursing staff is monitoring intake. Certified Nurse Assistants track the intake of meals and record them in the electronic medical record. They have not received any recent reports from nursing about Resident #93's intake but has been told it continues to be poor and no recent emesis (vomiting) reported. Weights are discussed in morning meeting. Stated they have not had a formal discussion with the physician about Resident #93's weight loss, but the physician is provided with the Mini Nutrition Assessment for all residents quarterly, annually, if significant change, and on admission. Resident #93 was scored as 7 (malnourished) on their last Mini Nutrition Assessment. The physician should also be aware of Resident #93's weight loss from recorded weights in the electronic medical record, the dietician's notes, and any requests/suggestions the dietician makes through the Physician/Nurse Practitioner communication books that are on the units.</p> <p>During an interview on 12/20/24 at 4:49PM, Nurse Practitioner #1 stated that no one has reported Resident#93's weight loss to them. Stated that the nursing or dietary staff would tell them verbally or put it in the communication book. Stated that they have not received any messages from the Dietician or Nursing regarding Resident #93's weight loss. When made aware of Resident #93's weight loss in the last month alone, Nurse Practitioner #1 stated that they did see Resident #93 recently and thought they looked smaller, but nothing was reported to them. Stated that no additional interventions were put in place as they were not aware.</p> <p>During an interview on 12/22/24 at 12:38 PM, the Director of Nursing stated that the weights for residents are in the electronic medical record. Stated that Resident #93 did have recent transfers to the hospital, and they thought their weight loss was more Gastrointestinal related. The Director of Nursing stated they have spoken to the family in the past regarding the resident's general condition/decline. Stated that significant weight losses are discussed in morning meeting once a week but doesn't remember speaking about Resident #93 specifically. Stated the physician should have acknowledged the weight loss in progress notes.</p> <p>During an interview on 12/22/24 at 1:10 PM, the Medical Director stated that they will have to review Resident #93's chart to discuss the weight loss. Stated they will return call to discuss once they have reviewed the record.</p> <p>10NYCRR 415.12(j)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51214</p> <p>Based on observation, interview, and record review conducted during the Recertification Survey from 12/15-12/22/24, the facility did not ensure residents who need respiratory care are provided such care, consistent with professional standards of practice and the comprehensive person-centered care plan for 2/2 residents reviewed for Respiratory Care (Resident #75 and Resident #89). Specifically, 1) Resident #75 was provided oxygen 2.5 liters via nasal cannula without a physician order and 2) Resident #89 with a physician order for oxygen 2 liters as needed via nasal cannula for saturation below 90% was observed with oxygen being administered at 3 liters via nasal cannula.</p> <p>The Findings include:</p> <p>Review of the facility policy titled Oxygen Therapy, last reviewed 5/26/22, documented that a physician's order is required to institute oxygen therapy. In an emergency situation, a licensed nurse may start oxygen therapy and obtain a physician's order as soon as possible. Furthermore it documents that when charting use of oxygen the reason for oxygen therapy should be documented.</p> <p>Review of the policy titled Comprehensive Care Plan, last reviewed 9/23/24, documented that [NAME] Hall Rehabilitation Center is dedicated to providing personalized, high-quality care for our residents using a comprehensive resident assessment and care planning process. Additionally, it documents that Residents CCP will be individualized and remain up-to-date, reflecting the resident's current status and needs. Any changes in a resident's health, preferences, or goals will prompt an immediate review and necessary updates to the CCP by the relevant interdisciplinary team member(s).</p> <p>Resident #75 had diagnoses including but not limited to, Unspecified Atrial Fibrillation (heart arrhythmia), Cough unspecified, Unspecified Bacterial Pneumonia.</p> <p>The Quarterly Minimum Data Set (an assessment tool) dated 9/20/24 documented Resident # 75 had severe cognitive impairment, no shortness of breath, and did not receive oxygen therapy.</p> <p>There was no documented physician order for the use of oxygen.</p> <p>During observation on 12/17/24 at 7:51 AM 12/18/24 at 8:43 AM, and 12/19/24 at 8:00 AM Resident #75 was observed with oxygen 2.5 liters in use via nasal cannula.</p> <p>During an interview on 12/19/24 at 09:24 AM Licensed Practical Nurse #14 reviewed the resident's electronic medical record and stated Resident #75 did not have an order for oxygen.</p> <p>During an interview on 12/19/24 at 09:33 AM, Unit Manager #1 stated they were unable to locate an oxygen order in the electronic medical record. Unit Manager #1 stated they were not aware Resident #75 was receiving oxygen. Unit Manager #1 stated medication nurses would be expected to let the unit manager know and/or update the communication book for physician/nurse practitioner if oxygen was being used and there was no order.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident #89 had diagnoses including but not limited to Unspecified Atrial Fibrillation (heart arrhythmia), Dyspnea (difficulty breathing) and Chronic Obstructive Pulmonary Disease (lung disease that depletes oxygen intake and may cause difficulty breathing).</p> <p>The 8/22/24 Physician Order documented oxygen 2 liters as needed via nasal cannula for saturation below 90% and monitor oxygen saturation every shift.</p> <p>The 11/22/24 Minimum Data Set documented Resident #89 had severe cognitive impairment, shortness of breath coding was not complete, and did not receive oxygen therapy.</p> <p>The December 2024 Medication Administration Record documented oxygen saturation was 94-98% with the exception of 88% on 12/19/24.</p> <p>During observation on 12/17/24 at 7:59 AM, 12/18/24 at 8:39 AM, and 12/19/24 at 11:42 AM Resident #89 was observed in bed with oxygen being administered at 3 liters via nasal cannula.</p> <p>During an interview on 12/19/24 at 09:17 AM, Licensed Practical Nurse #14 stated if oxygen saturation was above 90%, the resident would not have to use oxygen. Licensed Practical Nurse #14 stated Resident # 89's oxygen saturation had been over 90 % but today the oxygen saturation was reported as 88% with and without the use of oxygen.</p> <p>During an interview on 12/19/24 at 09:29 AM, Unit Manager #1 stated there was an additional order to monitor oxygen saturation every shift. Unit Manager #1 stated they did not pass medications for residents and would not monitor oxygen unless they needed to help with medication pass or resident care. Unit Manager #1 stated Resident #89 did get anxious therefore the oxygen was often left on for their comfort. Unit Manager #1 stated they would not want to leave the oxygen on/running if not medically indicated.</p> <p>10NYCRR 415.1(k)(7)</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 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.</p> <p>51214</p> <p>Based on observations, interviews and record review during the recertification survey conducted 12/15/24-12/22/24, the facility did not ensure that the Physician provided supervision of medical care for 1 of 1 resident (Resident #93) reviewed for Physician Services. Specifically, Resident #93 had a significant weight loss of 41 pounds, 145.8 pounds to 104.8 pounds or a 28.12% weight loss, in sixteen weeks (8/28/24-12/18/24), and there was no assessment specific to the recorded weight loss by the Physician.</p> <p>Findings include:</p> <p>Review of the Facility Policy titled Weight Monitoring last reviewed 9/20/24 documented that residents experiencing unplanned weight gains or losses will have such changes monitored and care plans revised, as necessary, by the Interdisciplinary Team. Furthermore, it documents that the Registered Dietician/ Dietary Technician is responsible for documentation regarding significant weight changes as well as notification to the attending physician. Dietary is also responsible for documenting a progress note and reviewing and revising the Comprehensive Care Plan, as necessary. The physician is responsible for documenting a medical note and implementing appropriate medical interventions.</p> <p>Resident #93 diagnoses included, but were not limited to, Huntington's Disease, Parkinson's Disease, and Gastritis.</p> <p>The Annual Minimum Data Set (an assessment tool) dated 11/4/24 documented Resident #93 required set up assistance for eating and oral hygiene. Resident #93's weight was 131 pounds and height 68 inches. Resident #93 had a weight loss of 5% in the last month and 10% in the last 6 months, and it was not a physician prescribed weight loss. No oral or dental conditions documented. No special treatments indicated.</p> <p>Comprehensive Care Plan dated 10/25/24 documented a Focus of Dietary-Nutrition Risk related to inadequate PO intake (meals and fluids) related to variable appetite and psychiatric illness as evidenced by consuming less than 50% of many meals provided, status post intravenous hydration, Schizoaffective Disorder.</p> <p>Goals included, but were not limited to, Resident #93 maintaining adequate nutritional status as evidenced by least restrictive diet tolerated, no signs or symptoms of malnutrition, no significant change from current body weight.</p> <p>Interventions included, but were not limited to, continue current diet consistency as tolerated, continue ensure order, encourage meals/fluids, assist as needed, encourage adequate hydration, and provide additional 240ml fluids Q shift, monitor for need of softer diet.</p> <p>Nurse Practitioner Progress Note dated 8/25/24 documented the reason for visit as increased confusion. Documented poor intake because Resident #93 does not enjoy the foods offered to him. Recommendations included to follow up with dietary to help arrange to have more foods offered that resident enjoys eating.</p> <p>(continued on next page)</p>		

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Facility Clinical Monitoring Record for Resident #93's weights from 7/1/24-12/22/24 documented a weight 145.8lbs on 8/28/24.</p> <p>Dietary Progress Note dated 8/28/24 documented Resident #93 noted with decreased appetite and PO intake of meals s/p recent hospitalization . Significant weight loss of 23.5%. Recommendations were to consider a more aggressive bowel regimen and document all BMs, recent labs (renal and hydration indices, electrolytes, CBC), honor food preferences, continue current oral supplementation and adjust based on any observed preference.</p> <p>Nurse Practitioner Progress Note dated 9/1/24 documented assessment for emesis. Documented lab work, Xray, and documented that intake adequate, but will consider intravenous fluid if clinically indicated.</p> <p>Nurse Practitioner Progress Note dated 9/3/24 documented follow up for confusion. Recommendation to monitor intake of food/liquid- if not eating/drinking will reattempt intravenous fluids.</p> <p>Physician Progress Note dated 9/17/24 documented follow up for emesis, documented as resolved, continue to monitor.</p> <p>The Facility Clinical Monitoring Record for Resident #93's weights from 7/1/24-12/22/24 documented a weight of 131lbs on 10/11/24.</p> <p>Physician Progress Note dated 10/15/24 for monthly renewal. Resident #93's weight documented as 172.3lbs and no documentation of weight loss.</p> <p>Nurse Practitioner Progress Note dated 10/18/24 for readmission to skilled nursing facility status post hospitalization . Recommendations included medications ordered on discharge from hospital. There was no documentation of the Resident #93's weight or weight loss.</p> <p>The Facility Clinical Monitoring Record for Resident #93's weights from 7/1/24-12/22/24 documented a weight of 119.8lbs on 11/12/24.</p> <p>Nurse Practitioner Progress Note for periodic medical review dated 11/16/24 did not document Resident #93's weight or weight loss.</p> <p>Physician Order dated 12/2/24 documented Vitamin E 268mg (400 unit) capsule take 1 capsule by oral route once daily.</p> <p>Physician Progress Note dated 12/3/24 for readmission did not document Resident #93's weight or weight loss.</p> <p>Dietary Progress Note dated 12/4/24 documented a significant weight loss of 32.4% in less than 180 days.</p> <p>Recommended interventions included, but were not limited to, evaluate and discontinue unnecessary medications to limit pill burden, discontinue Vitamin E, continue current diet and Ensure, provide substitutes. No evidence of discussion of weight loss or recommendations with Physician.</p> <p>(continued on next page)</p>		

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Physician Orders dated 12/4/24 documented for Resident #93 House Diet, chopped consistency, thickened liquids-none. Special Instructions: Bland diet/chopped/thin.</p> <p>Ensure Clear 8 oz Frequency TID or ad lib, alternate with Ensure clear if one or the other declined.</p> <p>Ensure Plus 8oz Frequency TID or ad lib, alternate with ensure plus if one or the other is declined.</p> <p>Nurse Practitioner Progress Note dated 12/5/24 for readmission for enteritis did not document Resident #93's weight or weight loss.</p> <p>Nurse Practitioner Progress Note dated 12/8/24 for enteritis did not document Resident #93's weight or weight loss.</p> <p>Nurse Practitioner Progress Note dated 12/9/24 did not document Resident #93's weight or weight loss.</p> <p>The Facility Clinical Monitoring Record for Resident #93's weights from 7/1/24-12/22/24 documented a weight of 109.2lbs on 12/11/24.</p> <p>During an observation on 12/17/24 at 08:25 AM, Resident #93 was observed lying in bed, breakfast tray at bedside, tray set up for resident, resident not eating. At 08:39 AM, resident breakfast tray observed at bedside. Staff member entered room, observed staff removing tray from bedside, no significant consumption noted from tray.</p> <p>During an observation on 12/18/24 at 08:36 AM, Resident #93 observed lying flat in bed, meal tray on bedside table, no staff assisting with feeding. At 9:46AM resident observed in bed, lying flat, breakfast tray remains on bedside table small amount of food appears to have been eaten.</p> <p>During an observation on 12/18/24 at 12:24 PM, Resident #93 was given lunch tray-set up, assist provided by Certified Nursing Assistant, resident sitting at side of bed looking at tray, no staff assistance observed with feeding. Resident #93 was then laid back down in bed. At 12:44 PM, observed Certified Nursing Assistant in room with Resident #93, provided resident with fluids and verbal encouragement to eat, however, resident stated, no don't want that.</p> <p>The Facility Clinical Monitoring Record for Resident #93's weights from 7/1/24-12/22/24 documented a weight 104.8lbs on 12/18/24.</p> <p>During an observation on 12/20/24 at 08:34 AM, Resident #93 observed sitting up in dining room in wheelchair, breakfast tray provided to resident, no assistance or encouragement with eating observed. Resident preparing tea independently, playing with straw, drinking fluids intermittently. At 08:50 AM, resident remains sitting at table with breakfast tray, not eating any of the food on tray, no assistance/encouragement observed by staff, resident drank some fluids with eyes half closed. At 09:01 AM nurse feeding another resident at table provided verbal encouragement to Resident #93 to eat but resident did not consume any food. Resident picking at teeth with straw.</p> <p>(continued on next page)</p>		

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/20/24 at 11:03 AM, the Registered Dietician stated that Resident #93 is on weekly weights currently. Stated that the Resident #93's weight on 7/20/24 was 172.3lbs and after their return from the hospital, it was 148.8lbs. Stated that Resident #93 has continued to lose weight since then. Resident #93's weight on 12/18/24 was 104.8lbs. Stated that the interventions in place for resident include supplements-Ensure, bland diet for gastric issues, discontinuing unnecessary meds including vitamin E, and encouragement with meals. Reviewed resident risk factors including a Body Mass Index of 17.8 and Gastric Medical Issues (stomach issues). Stated that Nursing is monitoring resident intake. Stated Certified Nursing Assistant's track the intake of meals and record resident's intake in Sigma. Stated weights are also recorded in Sigma. Stated that there have been no recent reports from nursing about a decrease in resident's intake, however, they have been told that resident's intake remains poor and that they have not had any recent emesis (vomiting). Stated they have not had a formal discussion with the Physician about this resident's weight loss, but the Physician is provided with the Mini Nutrition Assessment for all residents quarterly, annually, if there is significant change, and on admission. Stated Resident #93 was scored as 7 (malnourished) on last Mini Nutrition Assessment. Also stated, the Physician should be aware of Resident #93's weight loss from recorded weights in the electronic medical record, the dietician's notes, and any requests/suggestions the dietician makes through the Physician/Nurse Practitioner communication books that are on the units. Stated they believed the Physician was aware.</p> <p>During an interview on 12/20/24 at 04:49PM, Nurse Practitioner #1 stated that no one has come to them to report Resident #93's weight loss. Stated that the nursing or dietary staff would tell her verbally or put it in the communication book. Stated that they have not received any messages on Resident #93's weight loss from the Dietician or Nursing staff. When made aware of Resident #93's weight loss in last month, Nurse Practitioner #1 stated that she did see the resident recently and thought they looked smaller, but nothing has been reported. Stated that no additional interventions were put in place as they were not aware of weight loss.</p> <p>During an interview on 12/22/24 at 12:38 PM, the Director of Nursing stated that the weights for residents are in the electronic medical record. Stated that Resident #93 did have recent transfers to the hospital, and they thought the weight loss was more GI related. Stated that significant weight losses are discussed in morning meeting once a week but doesn't remember speaking about Resident #93. Stated the Physician should have acknowledged the weight loss in progress notes.</p> <p>During an interview on 12/22/24 at 01:10 PM, the Medical Director stated that they will have to review Resident #93's chart to discuss the resident's weight loss. Stated they will return call to discuss once they have reviewed the record.</p> <p>10NYCRR 415.15(b)(1)(i)(ii)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47626</p> <p>Based on observation, interviews, and record review conducted during a Recertification Survey from 12/15/24-12/22/24, the facility did not ensure sufficient nursing staff to provide nursing and related services to attain or maintain the well-being of each resident in accordance with the facility assessment. This was evident for 17 of 90 shifts from 11/20/2024-12/20/2024 during the staffing review. Specifically, the facility triggered a 1-star rating in the payroll-based journal report. A review of the Facility Assessment documented minimal staffing levels required to provide residents quality of care and services. The facility's actual staffing reports revealed that they did not meet those staffing levels the facility did not provide actual staffing as documented in their Facility Assessment.</p> <p>The findings are:</p> <p>A review of the Facility assessment dated [DATE], documented the minimum staffing levels for the building are:</p> <p>1 Registered Nurse per shift: 7AM-3PM, 3PM-11PM, 11PM-7AM</p> <p>5 Licensed Practical Nurses per shift: 7AM-3PM, 3PM-11PM, 11PM-7AM</p> <p>12 Certified Nursing Assistants on 7-3 and 3-11, 6 on 11-7</p> <p>4 Licensed Practical Nurses on weekends during the 7AM-3PM and 3PM-11PM shifts, and 2 during 11PM-7AM shift.</p> <p>10 Certified Nursing Assistants on weekends during 7AM-3PM and 3PM-11PM, and 6 on 11PM-7AM shift.</p> <p>Staffing Audits provided and reviewed, documented for the weeks of 11/20/24, 11/27/24, 12/4/24 and 12/11/24 the facility failed to meet sufficient staffing level.</p> <p>A review of the actual staffing sheets revealed the following number of staff on duty.</p> <p>On 11/20/24 3PM-11PM (Evening) had 9 Certified Nurse Aides</p> <p>On 11/21/24 3PM-11PM had 11 Certified Nurse Aides</p> <p>On 11/22/24 7AM-3PM(Day) shift had 4 Licensed Practical Nurses.</p> <p>On 11/23/24 3PM-11PM had 8 Certified Nurse Aides.</p> <p>On 11/24/24 3PM-11PM had 8 Certified Nurse Aides.</p> <p>On 11/25/24 7AM-3PM had 11 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 - Some</p>	<p>On 11/26/24 3PM-11PM had 11 Certified Nurse Aides.</p> <p>On 11/28/24 7AM-3PM had 9 Certified Nurse Aides.</p> <p>On 11/29/24 11PM-7AM (Night Shift) had 4 Certified Nurse Aides.</p> <p>On 11/29/24 7AM-3PM had 3 License Practical Nurses.</p> <p>On 11/29/24 3PM-11PM had 4 Licensed Practical Nurses.</p> <p>On 12/1/24 3PM-11PM had 9 Certified Nurse Aides.</p> <p>On 12/1/24 11PM-7AM had 5 Certified Nurse Aides.</p> <p>On 12/13/24 7AM-3PM had 9 Certified Nurse Aides.</p> <p>On 12/13/24 3PM-11PM had 9 Certified Nurse Aides.</p> <p>On 12/14/24 11PM-7AM had 4 Certified Nurse Aides.</p> <p>On 12/16/24 7AM-3PM had 8 Certified Nurse Aides.</p> <p>During an interview on 12/16/24 05:26 PM Resident #12 stated that sometimes it takes 2 hours for them to answer my bell they do not have enough staff.</p> <p>During a meeting of the resident council with the surveyor on 12/16/224 at 1:25 PM the consensus from the residents present at the meeting was that staffing could be better. Multiple residents present stated that the staff do not come right away when they ring the call bell. Additionally, the residents stated they also often come in the room in response to bell, shut off the bell, state they will be back but then don't come back.</p> <p>During an interview on 12/21/24 at 12:00 PM the Human Resource Director stated that the facility tries hard to meet the staffing levels required by their faciliy assessment. Although they use agency staff as needed to meet the staffing needs this is also a challenge. Agency staff often do not have set schedules, as they determine when they want to work. In order to recruit staff they do offer bonuses. They stated that they use nurses to cover if we they are short Certified Nurse Aides. The management team is always on the units helping, and answer bells and get the nurse when needed.</p> <p>During an interview on 12/21/24 12:22 PM the Administrator stated they were aware that staffing has been difficult. They have been running ads to hire staff. They offer bonuses to increase recruitment. They do use agencies to fill opennursing positions. They stated that administration makes frequent rounds on the units to ensure the residents are receiving care.</p> <p>10NYCRR 415.13(A)(1) (i-i</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>44673</p> <p>Based on observation, record review, and interview conducted during the recertification survey from 12/15/24-12/22/24, the facility did not ensure that drugs and biological's in 1 of 2 medication storage areas were labeled and stored in accordance with professional standards. Specifically, antibiotics and intravenous fluids were found expired in the medication storage room.</p> <p>The findings include:</p> <p>The policy and procedure titled Storage of Drugs revised 9/17 documented, discontinued drug containers shall be removed from the medication cart, and marked to indicate that the drug has been discontinued. Discontinued drugs shall be disposed.</p> <p>During an observation on 12/19/24 at 9:32 AM in the medication storage room on the first floor, Piperacillin and Tazobactam 3.375 (an antibiotic to treat bacterial infections) with an expiration date of October 2024 and 1000 milliliters of intravenous fluids with an expirations date of October 2024 were identified.</p> <p>During an interview on 12/19/24 at 9:32 AM, Staff #14 stated that medications were checked for expiration dates, and the night nurse was responsible for removing expired medications and returning them to the pharmacy.</p> <p>During an interview on 12/19/24 at 2:00 PM the Director of Nursing stated, expired medications should be removed from the medications rooms and sent back to the pharmacy. Expired medications should not remain in the medication storage room.</p> <p>10 NYCRR 415.18(e)(1-4)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>44673</p> <p>FACILITY</p> <p>Extended Survey</p> <p>Based on observation, record review and interview conducted during a recertification, abbreviated, and extended survey from 12/15/24-12/22/24 (complaint # NY00359302), the facility did not ensure that operative oversight for an effective system was in place to maintain health, safety, and the highest practicable well-being of residents. reviewed for accidents. Specifically, 1) the facility failed to provide adequate supervision to prevent accidents from smoking for 1 out of 3 residents reviewed for accidents. The facility Administrator did not ensure that smoking was not allowed in the facility grounds. 2) The facility Administrator did not ensure that employees were periodically instructed and followed the general fire procedures in accordance with the facility's Fire Emergency Plan, or that it conducted the required number of fire drills per quarter. 3) The Administrator did not ensure that its emergency preparedness plans were updated and that staff were trained annually. 4) In addition the facility did not ensure that staff were offered the updated COVID-19 vaccinations. 5) The facility did not ensure adequate nursing staffing levels to meet the resident needs as documented in their facility assessments.</p> <p>The findings are:</p> <p>The facility was cited for the following areas of non-compliance. Details of these citations can be found in this Statement of deficiencies.</p> <p>F689- The facility failed to provide adequate supervision to prevent accidents related to smoking for 6 of 6 residents (#2, #6, #9, #29, #41 and #54) identified as smokers. Specifically, Resident #41 was a known smoker in a non-smoking facility and the facility failed to complete safety assessments or develop and implement a plan of care to ensure their safety, when it was known that the resident continued to smoke outside of the facility. On 11/1/2024 a fire was started on the outside patio when Resident #41 threw a cigarette butt into dry leaves. There were no facility staff supervising the resident during this smoking activity.</p> <p>0711 Based on record review and staff interviews, the facility did not ensure that employees are periodically instructed and follow the general fire procedures in accordance with the facility's Fire Emergency Plan. This is evidenced by the fact that staff members did not respond appropriately to an actual fire emergency that occurred on 11/01/2024 at approximately 4:15 PM; the facility failed to activate the fire alarm and to contact the fire department upon discover of the fire emergency.</p> <p>0712-Based on record review and staff interview, the facility did not ensure that fire drills were conducted quarterly on each shift, and that written records included which emergency fire conditions were simulated during each fire drill in accordance with NFPA 101: Life Safety Code.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>0741-Based on observation, record review and staff interviews, the facility did not ensure that smoking was not allowed in the facility grounds for a smoke free facility. Specifically, the facility is a nonsmoking facility and smoking was witnessed during the survey.</p> <p>E004-Based on document review and staff interviews, the facility did not ensure that its Emergency Preparedness Plan was reviewed and/or updated at least annually.</p> <p>E0037-Based on document review and staff interviews, the facility did not ensure that emergency preparedness training was provided to all staff at least annually.</p> <p>E0039- Based on document review and staff interviews, the facility did not ensure that the emergency preparedness testing requirements were in compliance with the requirements set forth in 483.73(d)(2). Specifically, the facility did not participate in an additional full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based exercise.</p> <p>F725-The facility did not ensure sufficient nursing staff to provide nursing and related services to attain or maintain the well-being of each resident in accordance with the facility assessment. This was evident for 17 of 90 shifts from 11/20/2024-12/20/2024 during the staffing review. Specifically, the facility triggered a 1-star rating in the payroll-based journal report. A review of the Facility Assessment documented minimal staffing levels required to provide residents quality of care and services. The facility's actual staffing reports revealed that they did not meet those staffing levels the facility did not provide actual staffing as documented in their Facility Assessment.</p> <p>F887-Based on interview and record review during the recertification survey conducted 12/15/24-12/22/24, the facility did not ensure each staff member was screened, offered the COVID-19 vaccine, and provided education regarding the benefits, risks and potential side effects associated with the vaccine for 10 of 10 staff reviewed for COVID vaccines. Specifically, there was no documented evidence of immunization records for COVID-19 vaccine for Registered Nurse Supervisor #2, Receptionist #3, Licensed Practical Nurse # 21 Certified Nurse Aid #9#22, #23,#24, Physical Therapist #25, [NAME] #26 and Maintenance staff #27.</p> <p>During an interview on 12/15/2024 at 10:30 AM, the Administrator stated it was a non-smoking facility and they were aware there were residents that smoked. They stated residents that smoked were care planned for non-compliance with the smoking policy. They stated the patio was unsupervised, and the residents could come and go independently. The Administrator provided a list of 6 residents including Residents #2, #6, #9, #29, #41, and #54 who were identified as smokers.</p> <p>During an interview on 12/15/24 at 1:46 PM the Registered Nurse Supervisor stated this is a non-smoking facility when the resident go out with their family they smoke, they are not supposed to smoke on the patio, but some of the resident smoke on the patio.</p> <p>During an interview on 12/16/24 at 1:15 PM The Maintenance Director, stated that he does not know if the wooden gazebo is fireproofed.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Campbell Hall Rehabilitation Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 23 Kiernan Rd Campbell Hall, NY 10916	
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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 12/20/24 at 3:21 PM with the Director of Nursing who is also the Infection Preventionist on record, they stated they have not been offering and keeping track of COVID-19 vaccines for staff and had problems with staffing, so have not gotten around to getting the COVID-19 status for staff. The Director of Nursing stated they got pulled from one project to the other and had not gotten back to organize the offering of COVID-19 vaccines for staff. I do not have any staff declination forms for the COVID-19 vaccine to show you.</p> <p>10NYCRR 483.70(1)</p>		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</p> <p>44673</p> <p>Based on observation, record review, and interviews conducted during the recertification, abbreviated (NY00359302), and extended survey from 12/15/24 to 12/22/24 it was determined the facility did not ensure a process or frequency for the reporting by the Administrator to the governing body. The method of communication was not documented, and the governing body failed to establish and implement procedures for a clear line of communication regarding the management and operation of the facility. Specifically, the facility failed to provide adequate supervision to prevent accidents from smoking for six residents who were known smokers. Several observations documented residents smoking on the patio and gazebo, despite the facility being a nonsmoking facility. A fire occurred on 11/1/24, on the patio due to a discarded cigarette butt.</p> <p>Findings include:</p> <p>The facility was cited under Tag F 689 at Immediate Jeopardy scope and severity J.</p> <p>The facility did not provide documented evidence of a Quality Assurance Performance Improvement plan or action to address identified issues related to smoking. The facility also did not have proper or thorough documentation or evidence of Quality Assurance Performance Improvement meetings to address residents smoking unsupervised on the patio and gazebo.</p> <p>During an interview on 12/15/24 at 10:30 AM, the Administrator stated that the facility was a non-smoking facility but acknowledged that residents smoked in the facility though their smoking was not in compliance with the facility's policies. The administrator stated that no Quality Assurance Performance Improvement meeting was held to address the issue of smoking, but that the residents that smoked were care planned for non-compliance. The Administrator stated that the patio and gazebo areas were unsupervised, and the residents could come and go at their discretion. The Administrator provided a list of 6 residents, resident #2, #6, #9, #29, #41, and #54 who were identified as smokers.</p> <p>During an interview with the Director of Nursing on 12/18/24 at 3:00 PM they stated that the facility is a non-smoking facility, that the residents that smoke have a non-compliance care plan, that they were not aware that the residents were smoking in their rooms, and that the smoking issue was not reported to the Quality Assurance/Performance Improvement committee.</p> <p>During an interview with the Medical Director on 12/22/24 at 1:00 PM they stated that they were not aware of residents smoking in the facility or that there had been a smoking related fire at the facility. The Medical Director stated that there were no agenda items related to smoking presented to the Quality Assurance/Performance Improvement committee.</p> <p>During an interview with the owner of the facility on 12/22/24 at 2:30 PM they stated that they were aware that residents smoke at the facility. The owner stated that the issue of smoking at the facility was not brought to the attention of the Quality Assurance/Performance Improvement committee. The owner added that they have some problematic residents which they have been trying to discharge.</p> <p>(continued on next page)</p>		

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow up interview on 12/22/24 at 4:00 PM the Administrator stated that the smoking issue was not brought to the attention of the Quality Assurance/Performance Improvement committee. 10NYCRR 415.26(b)(3)(1)

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41666</p> <p>Based on observation, record review and interview conducted during a Recertification survey from 12/15/24-12/20/24, the facility did not ensure infection control prevention practices were maintained to prevent the development and transmission of communicable diseases and infection and did not ensure there was a system for preventing, identifying, reporting, investigating, and controlling infection and communicable disease for all residents.</p> <p>Specifically, 1) there was no evidence that a Water Management Plan was in place to prevent and control Legionella, a Facility Risk Assessment was completed, or that Legionella testing was performed within the last year, 2) the facility did not effectively implement accurate tracking and monitoring of infection and outbreak among residents to prevent further spread of infection and early identification of outbreaks and 3) the facility did not provide documentation of screening, administration or declination and education provided for 3 of 10 staff (Certified Nurse Aide #9, Registered Nurse Supervisor #2 and Receptionist #3) reviewed for influenza vaccination and 10 of 10 staff reviewed for pneumococcal vaccination (Registered Nurse Supervisor #2, Receptionist #3, Licensed Practical Nurse # 21 Certified Nurse Aide #9, #22, #23, #24, Physical Therapist #25, [NAME] #26 and Maintenance Staff #27).</p> <p>The findings are:</p> <p>1) The facility's Policy and Procedure for Legionella updated on 6/2019 documented routine Legionella culture sampling and analysis will be performed every year, maintenance department employees will take a water sample from each of three zones annually, specified records will be retained, including the environmental assessment, the sampling and management plan, and any associated sampling results on the facility's premises for a minimum of three years and such records will be available to the Department of Health upon request.</p> <p>Review of the facility's Legionella records revealed the last lab sample for Legionella detection was collected on 02/08/2023 with an analyzed date of 02/21/2023. The report indicated Legionella was not detected.</p> <p>There was no documented evidence for Legionella testing within the last year.</p> <p>There was no documented evidence for completion of an Environmental Risk Assessment within the last year.</p> <p>There was no documented evidence that a Water Management Plan was in place to prevent and control Legionella.</p> <p>On December 19, 2024, at approximately 9:08 AM, the Administrator stated lab results provided for review were for the last test completed, and there had not been any Legionella testing done in 2024.</p> <p>On December 19, 2024, at approximately 2:30 PM, the owner stated they would search for the risk assessment and the water management plan and would provide it for review.</p> <p>(continued on next page)</p>		

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

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666</p> <p>Based on record review and interview during the recertification survey conducted 12/16/24 to 12/22/24, the facility did not ensure each resident was offered pneumococcal immunizations and received education regarding the benefits and potential side effects of the immunizations for 1 of 5 residents (Residents #79) reviewed. Specifically, there was no documented evidence Resident #79 was offered, declined, or educated about the pneumococcal immunization.</p> <p>Findings include:</p> <p>The undated facility policy titled Pneumococcal Vaccination documented the Pneumovax vaccine will be available to all residents at [NAME] Hall Rehabilitation Center to aid in the control and spread of pneumonia between residents and staff. Residents at any age who have long term health problems are at high risk of contracting pneumonia. All residents who have no documentation of previous pneumococcal vaccine shall receive the vaccine upon admission. Pneumococcal vaccination will be recorded on the immunization record. Before offering the vaccine each resident or the resident's legal representative will receive education regarding the benefits and potential side effects of the vaccine.</p> <p>Resident #79 had diagnoses including Chronic Obstructive Pulmonary Disease, Type II Diabetes Mellitus and Malignant Neoplasm of kidney.</p> <p>The Minimum Data Set (an assessment tool) dated 10/11/24 documented Resident #79 had severe cognitive impairment.</p> <p>There was no documented evidence the resident/resident representative received education, was offered the vaccination, or declined the pneumococcal vaccine.</p> <p>During an interview on 12/20/24 at 3:21PM the Director of Nursing stated they are in the process of training the new Infection Preventionist and tried to stay on top of the vaccine records for residents, but has only been able to organize influenza vaccines. They stated they did not have the pneumococcal vaccination records in order and did not have records of declinations.</p> <p>10NYCRR 415.19 (a) (1-3)</p>

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>41666</p> <p>Based on interview and record review during the recertification survey conducted 12/15/24-12/22/24, the facility did not ensure each staff member was screened, offered the COVID-19 vaccine, and provided education regarding the benefits, risks and potential side effects associated with the vaccine for 10 of 10 staff reviewed for COVID vaccines. Specifically, there was no documented evidence of immunization records for COVID-19 vaccine for Registered Nurse Supervisor #2, Receptionist #3, Licensed Practical Nurse # 21 Certified Nurse Aid #9#22, #23,#24, Physical Therapist #25, [NAME] #26 and Maintenance staff #27.</p> <p>Findings include:</p> <p>The facility policy titled COVID-19 Vaccination for Residents and Staff dated 5/15/2021 documented the purpose of COVID-19 vaccination is to minimize the risk of acquiring, transmitting, or experiencing complications from COVID-19 by offering residents and staff members immunization to COVID-19. Before offering COVID-19 vaccine all staff members are provided education regarding the benefits and risks and potential side effects associated with the vaccine.</p> <p>Dear Administrator Letter dated 9/13/2023 documents: The purpose of this letter is to remind nursing homes of the expectation that they exercise diligence, act proactively and document efforts to ensure that all residents and staff who are eligible and consent to COVID-19 vaccination remain up to date with all Centers for Disease Control and Prevention (CDC) recommended COVID -19 vaccine doses. In addition, consistent with regulation nursing homes must: 1) Offer all consenting, unvaccinated existing personnel and residents an opportunity to receive the first or any recommended next or booster dose of the COVID-19 vaccine. (10NYCRR:66-4.1(a) 2) Ensure that all new personnel, including employees and contract staff, and every new resident and resident readmitted to the nursing home, has an opportunity to receive the first or any recommended next or booster dose of the COVID-19 vaccine within fourteen days of having been hired by or admitted or readmitted to the nursing home. (10NYCRR:66-4.1(b) 3) Provide all personnel and residents who decline to be vaccinated a written affirmation for their signature, which indicates that they were offered the opportunity for a COVID-19 vaccination but declined. Such affirmation must state that the signatory is aware that, if they later decide to be vaccinated for COVID-19, it is their responsibility to request vaccination from the facility. The facility shall maintain signed affirmations on file at the facility and make such forms available at the request of the Department. (10NYCRR:66 4.1(c)(2)</p> <p>There was no documented evidence the facility had documentation of screening, education offering, current COVID-19 vaccine booster status or a signed declination form from: Registered Nurse Supervisor #2, Receptionist #3, Licensed Practical Nurse # 21 Certified Nurse Aid #9 #22, #23,#24, Physical Therapist #25, [NAME] #26 and Maintenance staff #27.</p> <p>(continued on next page)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 12/20/24 at 3:21 PM with the Director of Nursing who is also the Infection Preventionist on record, they stated they have not been offering and keeping track of COVID-19 vaccines for staff and had problems with staffing, so have not gotten around to getting the COVID-19 status for staff. The Director of Nursing stated they got pulled from one project to the other and had not gotten back to organize the offering of COVID-19 vaccines for staff. I do not have any staff declination forms for the COVID-19 vaccine to show you.</p> <p>10NYCRR 415.19 (a)(1-3)</p>		