STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335657	A. Building B. Wing	07/22/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interviews during the abbreviated and partial extended survey (NY00340632, NY00340457), the facility did not ensure all violations were thoroughly investigated and that results of all investigations were reported to the administrator and other designated representative and to other officials in accordance with State law, including the State Agency, within 5 working days of the incident and appropriate corrective action taken for 4 (Resident #1, #2, #3, #4) of 5 residents reviewed. Specifically, (1) Review of video surveillance dated 4/28/2024 revealed, Resident #1 was trying to exit the facility through the front door and a facility staff member was rushing from outside the facility through the outermost door and pushed the inside door against Resident #1, causing the resident to fall to the floor. The facility did not initiate an investigation into abuse until 4/29/2024, and the Director of Nursing was not notified of the incident until 4/29/2024. (2) The facility did not conduct a thorough investigation to determine the root cause to prevent reoccurrence of a resident-to-resident altercation involving Resident #2 and Resident #3. The facility did not provide a completed Incident/accident/investigative report for a previous resident to resident incident that occurred on 2/10/2024 involving Resident #2 and Resident #4. Findings include: Review of the facility Abuse identification program last reviewed 5/30/2022 documented the purpose of this policy is to provide employee's specific procedure and guidance in the identification, intervention and reporting of incidents of potential and actual abuse, neglect, mistreatment and/or misappropriation of resident's property, and to ensure all measures are taken to prevent abuse. This procedure follows New York State and Federal regulation. The employee who witnesses the abuse, suspects that the abuse may have occurred, or hears that abuse may have occurred, is to report the information to their immediate Supervisor without delay. The direct Supervisor of the shift is to report the incident without delay to the Director of Nursing Services, who will immediately commence a full investigation with the assistance of the Unit Manager and/or Nursing Supervisor. On the evening and night shift, weekends and holidays, the direct Supervisor will report the alleged abuse to the Nursing Supervisor who will immediately commence a full investigation. The Nursing Supervisor will immediately call the Director of Nursing and/or Administrator for consultation before the investigation and again when the investigation is completed. (1) Resident #1 was initially admitted to the facility 5/27/2022 and last readmitted on [DATE] with diagnosis including, but not limited to, Chronic Obstructive Pulmonary Disease (a disease characterized by persistent breathlessness and cough), schizoaffective disorder (a disorder that is marked by dramatic changes in their thoughts, mood, behaviors), and Alzheimer's disease. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Campbell Hall Rehabilitation Center Inc	23 Kiernan Rd Campbell Hall, NY 10916

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A quarterly Minimum Data Set (an assessment tool) dated 5/22/2024 documented the resident had a Brief Interview for Mental Status score of 15 associated with intact cognition. The resident required set up assistance with eating, supervision for toileting, independent with bed mobility and transfers. The resident walks with a walker or transfers to wheelchair for locomotion, occasionally incontinent of bladder and frequently incontinent of bowel. The resident exhibited verbal behaviors directed towards others and wandering behaviors. Review of the video surveillance for 4/28/2024 at 5:45 AM revealed Resident #1 ambulating with a cane to the front doors of the lobby, wearing an open back gown and slippers. The front doors of the lobby are a double set. Resident #1 approached the inner lobby doors and attempted to open the door using their backside to thrust against it. Resident #1 then gets the door to open slightly and turns putting their foot into the doorway space along with their cane. As Resident #1 began to turn, Licensed Practical Nurse #1 is seen running from the parking lot and entering the first set of doors, and then pushing the inner door against Resident #1, causing Resident #1 to fall to the floor. Review of an internal investigation dated 5/2/2024 documented the nature of the incident as a resident fall that occurred on 4/28/2024 at approximately 5:30 AM, while the resident attempted to break open the inside front lobby door. The investigation concluded based on the facts of the investigation, the Director of Nursing's knowledge of Licensed Practical Nurse #1's reputation and integrity, and their body language noted immediately following the incident, support there is no reasonable cause to believe any alleged abuse, mistreatment, neglect, misappropriation of property occurred, or quality of care concerns had occurred. The Director of Nursing signed off on the investigative summary on 5/3/2024. The investigation documented Resident #1 was assessed for injury and refused first aid treatment and emergency room evaluation and treatment. The conclusion of the investigation was not submitted to New York State Department of Health. During an interview on 6/18/2024 at 10:20 AM and on 7/10/2024 at 1:22 PM the Director of Nursing stated the facility submitted a 5-day conclusion to the New York State Department of Health and they would have to check with the Administrator to see when it was submitted. The Director of Nursing stated they were not called by the Registered Nurse Supervisor after the incident. They found a report left in their mailbox on 4/29/2024 and that prompted them to watch the video surveillance. The Director of Nursing stated the facility called the police on Monday 4/29/2024. The Director of Nursing stated if the Administrator is not in the facility, they or the facility owner will be responsible to submit the report to the Department of Health. During an interview on 6/18/2024 at 1:15 PM and 7/10/2024 at 1:20PM, the Administrator stated they did not recall when they were informed of the incident that occurred on 4/28/2024. They may have been texted on a Sunday or informed when they arrived at the facility on Monday 4/29/2024. The Administrator stated they viewed the video surveillance on Monday 4/29/2024, and believe they submitted the results of the investigation to New York State Department of Health but do not know how to check the status after submission. They stated they know the results of the conclusion were not submitted timely. During a telephone interview on 7/10/2024 at 1:55 PM the facility owner stated the video surveillance was first viewed, the day after the incident on 4/29/2024. They stated the facility called the police on 4/29/2024. (continued on next page)

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Campbell Hall Rehabilitation Center Inc	23 Kiernan Rd Campbell Hall, NY 10916

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/11/2024 at 10:55 AM the Director of Nursing stated Licensed Practical Nurse #1 was not suspended during the investigation because the incident looked like an accident, and the Licensed Practical Nurse #1 was not written up and no in-services were provided to them after the incident. During a telephone interview on 7/11/2024 at 3:30PM, Registered Nurse Supervisor #1 stated they placed the incident report in the Director of Nursing's box at the end of their shift on 4/29/2024 and did not call the Director of Nursing when the incident occurred. They stated the Director of Nursing found out about the incident on Monday morning 4/29/2024 when they arrived at the facility. (2) Resident #2 was initially admitted to the facility on [DATE] and last readmitted on [DATE] with diagnosis including, but not limited to, Alzheimer's disease, Dementia, and muscle weakness. An Annual Minimum Data Set, dated dated dated [DATE] documented Resident #2 had severe cognitive impairment; exhibits verbal, and physical behaviors directed towards others and worsening behaviors over time; required set up assistance for meals, dependent for toileting and moderate assistance for bed mobility and transfers; and uses the wheelchair for locomotion. Review of the resident's Admission/Discharge/Transfer record documented Resident #2 had a room change on 2/10/2024 because they did not get along with their roommate. A nursing progress note dated 2/10/24 at 9:55 PM documented Resident #2 got out of bed and spilled juice all over their roommate (Resident #4). Resident #2 also yelled at Resident #4. All parties were separated. Resident #2 was moved to another room on 2/10/2024 due to aggressive behavior towards roommate. The facility could not provide an accident/incident report for the incident that occurred on 2/10/2024 involving Resident #2. Additionally, review of an incident report dated 4/19/2024 documented Resident #2 was found in bed with food stains noted on the wall and scratches to right side of the resident's face, with no bleeding. The report documented Resident #2 was unable to describe what occurred. The root cause analysis documented unable to determine what occurred. Resident #2 shared a room with Resident # 3. A nurse's note dated 04/20/2024 documented that on 4/19/2024 staff overheard raised voices from Resident #2 and Resident #3's room. Staff found food stains scattered on the walls and Resident #2, who is severely cognitively impaired, was noted to have 2 scratches, one to the outer area of their right eye (about 1cm) and one scratch noted to their neck area. There was no evidence that an investigation was initiated on 04/19/2024. Review of the investigative form dated 4/19/2024 documented no complaints received from Resident #2 or Resident #3. Summary of the Investigation and the conclusion documented unable to determine what occurred in the room. Corrective actions taken documented residents separated and assigned new rooms. Review of Resident #2's Admission/Discharge/Transfer record revealed Resident #2's room was changed on 4/24/2024 due to difficulty with roommate. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a Social Worker note dated 4/24/2024 at 2:38 PM documented an interview with Resident #3 regarding an incident involving Resident #2. The note documented Resident #3 reported that their roommate was throwing food at them and that they could not take it anymore, so they went to Resident #2's bedside and choked them by placing their hands around Resident #2's neck. During an interview on 6/17/2024 at 1:20 PM Resident #3 stated Resident #2 was throwing food at them which they had done before. Resident #3 stated they tried to walk away, and Resident #2 kept hollering at them and they lost it. Resident #3 stated they grabbed Resident #2 by the neck and choked them. During an interview on 6/18/2024 at 10:20 AM the Director of Nursing stated an investigation was completed, but no staff witnessed what occurred in the room. The Director of Nursing stated they separated Resident #2 and Resident #3 and moved their rooms. The Director of Nursing stated Resident #2 did have scratches to their neck, but it could have been from their own nails. The Director of Nursing could not recollect when the room change occurred. During a telephone interview on 6/24/2024 at 9:11 AM Registered Nurse Supervisor #1 stated after the incident on 4/19/2024, Resident #2 had scratches on their upper chest, but no one knew anything when the staff was asked. Registered Nurse Supervisor #1 stated it was hard for them to make a conclusion. They stated the incident occurred on the weekend and on Monday morning the facility was able to move beds around and give Resident #2 a different room. (3) Resident #3 was initially admitted to the facility on [DATE] and last readmitted on [DATE] with diagnosis including, but not limited to, Alzheimer's disease, Schizophrenia (mental illness that affects how the individual thinks, feels, and behaves causing them to have disorganized thoughts and behaviors) and Generalized Anxiety Disorder. A Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status score of 13 (BIMS, used to determine attention, orientation, and ability to recall information) associated with intact cognition. Resident #3 required set up for eating and toileting and supervision with bed mobility transfers. The resident exhibits rejection of care behaviors and uses a wheelchair for locomotion. Review of a behavior care plan dated 9/5/2023 documented the resident was noted with aggressive behavior towards another resident. There is no documented progress notes or incident reports related to any aggressive episode on 9/5/2023 and the facility could not provide the accident/incident report with interviews for this incident. Review of the Accident/Incident report for Resident #3 revealed the incident on 4/19/2024 occurred at 6:15 PM and Registered Nurse Supervisor #1 was not informed until 4/20/2024 at 1:05 AM. An interview with Resident #3 revealed they were not questioned by facility staff about the incident that occurred on 4/19/2024 until 4/24/2024 when the social worker spoke with them. Resident #3 reported to the social worker that they grabbed their roommate (Resident #2) by the neck and choked them. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/10/2024 at 10:15 PM the social worker stated they were asked to go and see Resident #3 due to an altercation between Resident #2 and Resident #3. The social worker stated Resident #3 informed them they choked their roommate because their roommate threw food on them. The administrator was informed of Resident #3's statement for follow up. The Social Worker stated they did not follow up with the resident after the initial interview. During an interview on 7/11/2024 at 10:55 AM the Director of Nursing stated they were unable to provide the incident reports for the incident that occurred with Resident #3 on 9/5/2023 or Resident #2 on 2/10/2024. (4) Resident # 4 was initially admitted to the facility on [DATE] and last readmitted on [DATE] with diagnosis including, but not limited to, End Stage Renal Disease (the loss of kidney function), anxiety disorder and Type 2 Diabetes Mellitus. A Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had a BIMS score of 12 indicating moderate cognitive impairment. No behaviors noted. Documented lower extremity impairment on both sides. Documented the resident required supervision with eating, maximal assistance with bed mobility and dependent for toileting and transfers. Review of a nursing progress note dated 2/10/2024 documented Resident #4's roommate (Resident #2) was moved to another room, because Resident #2 spilled juice all over Resident #4 and yelled at them to get out of their room. Resident #2 was moved to another room. The facility did not provide an incident report for the 2/10/2024 incident. During an interview on 7/11/2024 at 10:55 AM the Director of Nursing stated they were unable to provide the incident report for the incident that occurred with Resident #2 on 2/10/2024. During a telephone interview on 7/16/2024 at 2:00 PM Licensed Practical Nurse #1 stated they did not witness the incident between Resident #2 and Resident #4, but they were told by Resident #4 that Resident #2 was aggressive with them and poured juice on them. 10 NYCRR 483.12(c)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interviews during an abbreviated survey (NY00340632, NY00340457) the facility did not ensure the resident environment was free of accident hazards and that each resident received adequate supervision to prevent accidents for 1(Resident #1) out of 3 residents reviewed for accidents. Specifically, on 4/28/2024 at 5:45 AM Resident #1 is seen on video surveillance walking with their cane and pushed open the locked inner lobby door with their body. Licensed Practical Nurse #1 was seen coming from outside the facility, passed through the outer lobby door and pushed the inner lobby door against Resident #1, which caused Resident #1 to fall to the floor. Subsequently, Resident #1 sustained a bloody nose, black right eye, and a bruised left ankle. The actions taken by Licensed Practical Nurse #1 to stop Resident #1 from passing through the lobby door resulted in actual harm that is not immediate jeopardy. Findings include: Resident #1 was initially admitted to the facility with diagnosis including, but not limited to, Chronic Obstructive Pulmonary Disease (a disease characterized by persistent breathlessness and cough), schizoaffective disorder (a disorder that is marked by dramatic changes in their thoughts, mood, behaviors) and Alzheimer's disease. A quarterly Minimum Data Set (an assessment tool) dated 5/22/2024 documented Resident #1 had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 15, associated with intact cognition. Resident #1 required set up assistance with eating, supervision for toileting, and was independent for bed mobility and transfers. Resident #1 ambulated with a walker or used a wheelchair for locomotion. Resident #1 exhibited verbal behaviors directed towards others, wandering behaviors and was frequently incontinent of bowel and occasionally incontinent of bladder. Review of an elopement risk assessment dated [DATE] documented Resident #1 had a history of wandering, opening doors to the outside and/or elopement, and making statements about leaving. The assessment documented the facility will care plan as a high risk for elopement, educate staff and enter notation on certified nurse assistant accountability sheet. There was no documented evidence of any elopement measures/interventions in place. Review of a behavior care plan dated 3/25/2024 listed behavior problems as follows: verbally abusive, physically abusive, socially inappropriate/disruptive, resists care and resists medications. Interventions listed included: medical and psychiatric management as per physician's order, psychiatric evaluation and follow up, psychological services, administer psychoactive medications as per physician's order, provide emotional support, remove resident from public areas when behavior or language is unacceptable. There was no documentation identifying wandering as a behavior exhibited by the resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the admission assessment dated [DATE] documented Resident #1 had a history of falls and was a high risk for falls. Review of a Falls Care Plan dated 5/19/2024 documented no identified risk. Interventions listed included: ensure a safe clutter free environment, ensure proper footwear. The fall care plan was not updated with the incident that occurred on 4/28/2024. Review of the video surveillance for 4/28/2024 at 5:45 AM revealed Resident #1 ambulating with a cane to the facility front doors. Resident #1 bumped against the inner door, and it opened slightly. Resident #1 put their foot and cane into the space of the opened door. Licensed Practical Nurse #1 was seen running from the parking lot through the outer door and pushing the inner door against Resident #1 causing Resident #1 to fall to the ground. Review of Physician Assistant #1's progress note dated 4/30/2024 documented the reason for the consult was status post traumatic fall. The progress note documented Resident #1 had a fall to the floor over the last few days and the preceding events to the fall were under review. Physician Assistant # 1 documented Resident #1 reported they were stiff after the fall and upon examination Resident #1 had ecchymosis to the right eye orbit with no discernable tenderness and some swelling to lower extremity. Review of Physician Assistant #2's progress note dated 5/1/2024 documented Resident #1 presented for evaluation following a recent fall and x-ray review. Physician Assistant #2 documented the resident reported experiencing chest discomfort due to the fall and is currently on pain management medications. Physician Assistant #2 documented the resident is non-compliant with safety precautions and has a history of multiple falls. The assessment and plan documented status post fall, x-ray was reviewed and was negative for significant injury or fracture and resident was encouraged to adhere to safety precautions to prevent future falls. During an interview on 6/17/2024 at 2:40 PM Licensed Practical Nurse #1 stated they have been working in the facility for 4 and a 1/2 years. They stated they were outside in their car for break and saw Resident #1 walking in the lobby. When Resident #1 approached the front door, Licensed Practical Nurse #1 stated they got out of their car and ran to the door and tried to prevent Resident #1 from exiting. Licensed Practical Nurse #1 stated they did not realize Resident #1 was close to the door, because they were running, and their adrenaline was pumping. The Licensed Practical Nurse stated the door hit the resident and the resident fell to the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Licensed Practical Nurse #1 stated they entered the lobby, the alarm was sounding, so they reset the alarm, and called out for the supervisor from the lobby because they did not want to leave the resident alone. Licensed Practical Nurse #1 stated when Registered Nurse Supervisor #1 arrived, they assessed Resident #1, and they placed a wet cloth on the resident's face because the resident's nose was bleeding. Licensed Practical Nurse #1 stated they asked Resident #1 if anything hurt, and they stated only their nose hurt. Licensed Practical Nurse #1 stated they put Resident #1 into a wheelchair and took them to their room. The physician was made aware, and they ordered to send Resident #1 to the hospital. Licensed Practical Nurse #1 stated Resident #1 refused, despite encouragement. Licensed Practical Nurse #1 stated the resident had x-rays done to ensure there were no injuries. Licensed Practical Nurse #1 stated Resident #1 was known to attempt to exit the building and had previously exited the building. Licensed Practical Nurse #1 stated Resident #1 had broken the glass of the front door before. Licensed Practical Nurse #1 stated Resident #1 has had wander guards applied before, and they cut them off. Licensed Practical Nurse #1 stated Resident #1 kept saying they know Licensed Practical Nurse #1 did not mean it and that it was their fault. Licensed Practical Nurse #1 stated they believe the unit manager and the Director of Nursing made updates to the care plan after the incident. During an interview on 6/17/2024 at 3:00 PM Registered Nurse Supervisor #1 stated Resident #1 exited their room by the nurse's station and was going in the opposite direction towards the elevators in a hurry. Registered Nurse Supervisor #1 stated Resident #1 then leaned up against the wall because they were out of breath. They stated they got on the elevator to go look for Resident #1 and found them on the basement level. Registered Nurse Supervisor #1 stated Resident #1 told them to get off the elevator and stop following them, so they got off the elevator and got on the next one. Registered Nurse Supervisor #1 stated the elevators left the basement level at the same time, but by the time they got to the first floor they heard Resident #1 screaming and Licensed Practical Nurse #1 saying Resident #1 was hurt. Registered Nurse Supervisor #1 stated Resident #1 had a nosebleed and kept saying their nose was broken. They stated they did not witness the incident because by the time they got to the lobby, Resident #1 was already on the floor. Registered Nurse Supervisor #1 stated Resident #1 was frail, frequently ran out of breath, and used oxygen. During an interview on 6/18/2024 at 10:20 AM the Director of Nursing stated they were called and told Resident #1 had tried to get out of the building. The Director of Nursing stated prior to 2023, Resident #1 had broken the glass to the front door and tried to exit. Resident #1's behavior is more attention seeking than an elopement risk. They stated the facility has tried everything to make sure Resident #1 was safe and they tried to use wander guards, but Resident #1 is ambulatory with their walker or cane and takes the wander guard off. The Director of Nursing stated the resident is extremely accusatory. The Director of Nursing stated they have informally done 1:1 monitoring with Resident #1, but it is impossible to have a 1:1 monitoring in place due to the size of the building. The Director of Nursing stated these events happen with Resident #1 daily so someone would have to follow them all the time and that having 1:1 monitoring in place with Resident #1 may make the situation worse. During an interview on 6/18/2024 at 1:15 PM the Administrator stated Resident #1 does this all the time and previously had broken the front door glass. The Administrator stated Resident #1 is always trying to leave the building and once they are outside, they will just sit down. The Administrator stated Resident #1 is alert, and they will remove the wander guard if one is placed on them. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/10/2024 at 1:30 PM Resident #1 stated they remember running out of oxygen in their tank on 4/28/2024. Resident #1 stated they asked for another tank and the staff were taking too long, so they went to get one themself and they got very dizzy and could not make it to the oxygen tank. Resident #1 stated Registered Nurse Supervisor #1 showed up and tried to get them to sit down in another resident's wheelchair. Resident #1 stated they do not sit in other resident's wheelchairs. They stated they were out of it, but they were still refusing to sit in the wheelchair. Resident #1 stated Registered Nurse Supervisor #1 yelled out to the staff, this resident does not get help with anything, no oxygen, no nothing. They stated they needed oxygen, and they were dizzy. Resident #1 stated they know they could go to the front door and get more fresh air in between the front doors. They stated they bumped the front door open with their bottom and the next thing they knew they were being attacked from behind. Resident #1 stated their leg was locked between the 2 doors and Licensed Practical Nurse #1 slammed them down to the floor. Resident #1 stated blood was gushing out of their nose and lip and that they were on blood thinners. Resident #1 stated they also had pain in their chest, and they have a bad heart, and it felt like a knee was in their back. Resident #1 stated they were trying to get air when they tried to exit. Resident #1 stated they go outside when they need some air. The resident stated they were not trying to leave the building they were just trying to get some air. Resident #1 stated when they are dazed and confused, they may wander to the front door in attempt to get air. Resident #1 stated they are not allowed to have a one to one, even though they asked for that and the facility has more staff now. Resident #1 stated they hit the wrong button in the elevator and went to the basement level. The resident stated Registered Nurse Supervisor #1 came down in a separate elevator and asked why they went down there. During a telephone interview on 7/11/2024 at 11:20 AM Physician's Assistant #1 stated they believe the injuries sustained by Resident #1, matched the reported incident that occurred on 4/28/2024. Physician's Assistant #1 stated Resident #1 is a very aggressive individual, not only verbally but physically, and that Resident #1 was physically aggressive towards them before. Physician's Assistant #1 stated Resident #1 has a very unsteady gait and can barely walk with a walker, so having an injury or bruising is not unusual. They stated they were informed by the nursing staff that Resident #1 had a fall after trying to break the door down and sustained a bruise to their eye. 10 NYCRR 415.12(h)(2)

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

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 49372 Based on record review and interviews during an abbreviated and partial extended survey (NY00340632, NY00340457) the facility did not complete a performance review once every 12months for Certified Nurse Assistant reviewed. Of every nurse aide at least once every 12 months. Specifically, Certified Nurse Assistant #1's performance evaluation was last completed 2018. Certified Nurse Assistant #2's performance evaluation was last completed 2019. Findings include: Review of a sample of 2 certified nurse assistant (certified nurse assistant #1 and certified nurse assistant #2) employees files during onsite visit on 7/22/2024 revealed their performance evaluation was last completed in 2018 and 2019 respectively. There was no documented evidence that performance evaluations were completed from May 2022 to 7/22/2024. During an interview on 7/22/2024 at 1:50 PM the Human Resources Director/Scheduling Coordinator stated performance reviews are kept in employee personnel files. Staff education/competencies are kept in a separate file in the educator's office and staff mandatory trainings were completed in May 2024. All agency staff in the facility receive trainings upon starting. The Human Resources Director/Scheduling Coordinator stated performance evaluations have not been completed in the facility since 2022.The Department Head would be responsible for completing the performance evaluations. During an interview on 7/22/2024 at 1:55 PM the Director of Nursing stated performance evaluations have not been completed since her return to the role a year ago. Prior to that they did not complete any performance evaluations. The Director of Nursing stated there is no policy for performance reviews in place. They have not completed any because they have not had the chance to do so. 10 NYCRR 415.26

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50815 Based on record reviews and interviews during an abbreviated survey (NY00340632, NY00340457), the facility did not to ensure that the resident was provided with the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 2 (Residents #1 & #2) of 3 Residents reviewed for behavioral health. Specifically, (1) on 4/28/2024 at 5:45 AM, Resident #1 was seen on surveillance walking with unsteady gait and trying to exit the facility through the front door unsupervised; Resident # 1 was identified as an elopement risk, and a wanderer. The Behavioral Symptom Care Plan initiated on 2/29/2024 and updated on 3/25/2024 and 4/20/2024 had no identified goals and interventions to address the elopement and wandering behaviors and prevent reoccurrence, and to ensure the safety of the resident, other residents, and staff; (2)Resident # 2 who had a history of throwing food on roommates had no care plan goals or interventions in place to address the behavior. Findings include: Facility could not provide a Behavioral Health Policy upon request during the onsite visit on 6/24/2024. Resident #1 was readmitted to the facility on [DATE] with diagnoses including but not limited to, Schizoaffective Disorder, Alzheimer's Disease, and Chronic Disease. A Quarterly Minimum Data Set assessment dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 15/15, associated with intact cognition (00-07 severe impairment, 08-12 moderate impairment and 13-15 cognitively intact). Resident #1 was independent for bed mobility and transfers. Resident #1 ambulated with a walker or uses wheelchair for locomotion. Resident # 1 exhibited wandering behaviors and verbal behaviors directed towards others. Review of an elopement risk assessment dated [DATE] documented Resident #1 had a history of wandering (either in the facility or elsewhere), opening doors to the outside and/or elopement, and making statements about leaving. The assessment documented the facility will care plan as high risk for elopement, educate staff and enter notation on Certified Nurse Assistant accountability sheet. Review of a Behavioral Symptom Care Plan for Resident #1 initiated on 2/29/2024 identified Resident #1 as a risk for wandering into unsafe areas for elopement out of building without supervision. There were no documented goals/interventions to address the behavior and to prevent reoccurrence. Review of a Behavioral Symptom Care Plan dated 4/20/2024 documented Resident #1 has wandering behavior and at risk for wandering into unsafe areas and elopement out of building without supervision. There were no identified goals/interventions to address the behavior. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Behavioral Symptom Care Plan for Resident #1 dated 3/25/2024 documented Resident #1 was verbally abusive and physically abusive. There were no goals/interventions noted and no documented interventions to address attention seeking behaviors. During an interview on 6/18/2024 at 10:20 AM, the Director of Nursing stated they were called and told Resident #1 had tried to get out of the building. The Director of Nursing stated they were informed Resident #1's behaviors were over the top all night, and the staff could not satisfy the resident at all. The Director of Nursing stated that the elopement risk completed on 2/29/2024 was a mistake. The Director of Nursing stated Resident #1's behavior is attention seeking and was not an elopement risk. Resident #1 refuses psychiatry medications. During an interview on 6/18/2024 at 4:15PM, the facility owner stated that Resident #1 is a bully and knows what they are doing. The facility has tried to place Resident #1 into another facility with no success. (2) Resident # 2 was admitted to the facility on [DATE] and last readmitted on [DATE] with diagnoses including but not limited to Alzheimer's disease, Dementia, and muscle weakness. An Annual Minimum Data Set, dated dated dated [DATE] documented the resident had severe cognitive impairment. Resident #2 exhibits verbal, and physical behaviors directed towards others and that behaviors have worsened overtime. Resident # 2 required a set up for meals. Review of a Risk for Unsafe Behavior due to cognitive deficit initiated on 7/28/2021 and last updated on 11/15/2021 documented Resident #2 was at risk for unsafe behavior due to Alzheimer's disease. There were no goals or interventions noted. Review of a Risk for Unsafe Behavior due to cognitive deficit initiated 11/19/2021 and updated on 4/15/2022 documented Resident #2 was at risk for unsafe behavior due to Alzheimer's disease. There were no goals or interventions noted. Review of a nursing progress note dated 2/10/2024 at 9:55 PM documented Resident # 2 got out of bed and spilled juice all over roommate, and Resident #2 also yelled at roommate to get out. All parties were separated, and Resident #2 was moved to another room due to aggressive behavior towards roommate towards roommate. Responsible parties notified. Review of a nursing progress note dated 4/20/2024 at 12:02 AM documented staff reported hearing a verbal altercation coming from Resident #2 and Resident #3's room. The altercation was not witnessed and there were food stains on the wall near the head of Resident #2's bed. Resident #2 had scratch mark 1 cm long, near the outer area of right eye. The scratch was red without drainage or bleeding and some scratches were noted to the neck area. The Risk for Unsafe Behavior due to cognitive deficit initiated on 7/28/2021 and last updated on 11/15/2021. The Care plan was not updated with the incident that occurred on 2/10/2024 and/or 4/19/2024. Review of a behavior care plan dated 5/11/2024 initiated after the incidents had no documented goals or interventions for unsafe behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview at 7/19/2024 at 11:28AM, the Staff Educator stated care plans are initiated by Registered Nurses, and Licensed Practical Nurses update any significant changes. The Staff educator stated the facility does not have a training specific to behavioral health and they are in the process of creating one now. 10NYCRR 483.40

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50815 Based on record review and interviews conducted during an abbreviated survey and extended survey (NY00340632, NY00340457), the facility did not ensure that all staff were in serviced in the behavioral health needs of the residents. Specifically, the facility was unable to provide documented evidence that they provided staff education on behavioral health between 1/1/2024 and 7/2024. The findings are: A request was made for a Facility Behavioral Health Policy and procedure and was not provided prior to the exit date of 7/22/2024. A request was made for a Facility Behavioral Health in-services and staff education but was not provided until 7/22/2024. A Facility assessment dated [DATE] documented that the facility had a total bed capacity of 134 residents. The Facility Assessment documented common diagnosis of residents which include but not limited to Psychiatric/Mood Disorders, Neurological Systems and provides person-centered/direct care: psycho/social/spiritual support and mental and behavioral health services to residents. The Facility Assessment documented that all staff receive training and competencies upon hire, annually and on an ongoing basis for mental and behavioral health. During an interview on 7/19/2024 at 11:28 AM, the Registered Nurse Staff Educator stated there is no behavioral health training since they started working in the facility since May of 2024, and they are in the process of creating something. During an interview on 7/22/2024 at 9:40 AM, the Registered Nurse Staff Educator stated that they have created a behavioral health education plan and will be starting the education to all staff members on 7/23/2024. 483.40(a)(1)(2)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 49372 Based on record review and interviews during an abbreviated and partial extended survey (NY00340632, NY00340457), the facility was not administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, (1) Specifically, there was no documented evidence that the facility Assessment was reviewed and/or updated from 7/31/2021 to 7/18/2024; (2) The Facility experienced an Electronic System Outage during the extended survey on 7/19/2024, and the Administrator was not aware of the emergency plan or process for mitigating the occurrence; (3) the Facility Administrator did not report the results of all investigations to the New York State Departemnt of Health in accordance with State law for allegation of abuse that occurred on 4/19/2024 and an injury of unknown origin that occurred on 6/22/2024. Findings include: The Facility Assessment was requested for review on 7/17/2024. The Facility Assessment was provided to the surveyors on 7/19/2024. The Facility Assessment was without annual revisions and was dated 7/19/2024. During an interview on 7/17/2024 at 3:30 PM, the Administrator stated they are responsible for updating the Facility Assessment. The Administrator stated they were not familiar with the Facility Assessment requested. The Administrator stated they will contact another administrator who might be more familiar with the Facility assessment Document. The Administrator spoke to another Administrator on the phone, and they were informed to look for the plan management and to ask human resources. The Administrator stated the facility was last surveyed 4/2022 and they should be familiar with the Facility Assessment Document as they are responsible for updating it. (2) The facility experienced an Electronic Medical Record Transmittal System outage on 7/19/2024 from 5:30am to about 4pm. The Administrator was not knowledgeable of the emergency plan in place to ensure that nursing staff would have access to medical orders, medical administration records and treatment records to ensure timely provision of medications and treatments to the residents and did not report the incident to New York State Department of Health. During an interview on 7/19/2024 at 9:20 AM, the Administrator stated Sigma (the electronic medical record system is down and has been down since 5:30 AM but the general internet is working. The Administrator stated they have to look up the emergency plan for a system outage as they were unfamiliar with the plan. (3) The Facility Administrator did not report the results of all investigations to the New York State Departemnt of Health in accordance with State law for allegation of abuse that occurred on 4/19/2024 and an injury of unknown origin that occurred on 6/22/2024. There was no submission by the facility to New York State Department of Health for the incident on 6/22/2024 involving Resident #5. The results of the investigation were not submitted within 5-days as per regulation. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/18/2024 at 1:15 PM the Administrator stated they submitted the report to the New York State Department of Health. They stated an investigative report was submitted however they do not know how to confirm their entry. The Administrator stated they know the reports were not submitted within the correct timeframe. Stated they would call another Administrator and see if they could assist them with checking for it. 10NYCRR 415.26(a)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interviews during an abbreviated and partial extended survey (NY00340632, NY00340457), the facility did not ensure a facility-wide assessment was conducted and documented to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. Specifically, there was no Facility Assessment readily available for review upon request during the survey on 7/17/2024. There was no documented evidence that the Facility Assessment was reviewed/or updated from 7/31/2021 to 7/18/2024. Findings include: The Facility assessment dated [DATE] documented under requirement the Nursing facility will conduct, document and annually review a facility-wide assessment, which includes bith their resident population and the facility needs to care for their residents. the purpose was to use this assessment to make decisions about direct care staff needs, as well as capabilities to provide services to the residents in the facility. On 7/17/2024 at 8:30 AM the Facility Assessment was requested for review by the surveyors.The Administrator provided a Facility Survey Report on 7/17/2024. The facility did not provide the Facility Assessment document for review until 7/19/2024. On 7/19/2024 the Administrator provided a copy of a Facility Assessment Tool with a review date of 7/17/2024. During an interview on 7/17/2024 at 3:30 PM, the Administrator stated they could not locate the Facility Assessment and were not familiar with the document. The Administrator stated they are responsible for updating the Facility Assessment, and proceeded to reach out to a colleague who directed them to look for a plan management and to speak to Human Resources. The Administrator searched on the computer and stated they found the document and will be completing the information. The Administrator stated the last time the facility was surveyed in 4/2022 they presented the document and should be familiar with it. 483.70(e)(1)-(3)