STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335271	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dumont Center for Rehabilitation and Nursing Care	676 Pelham Road New Rochelle, NY 10805

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the Recertification and Abbreviated Survey (iQIES Incident 646938), the facility failed to ensure that the resident or their representative participated in all aspects of person-centered care planning. This was evident for one (1) (Resident #211) of two (2) residents reviewed for care planning out of 36 total sampled residents. Specifically, Resident #211's representative was not afforded the opportunity to participate in the resident's care planning process. The facility's policy titled Resident Assessment Instrument and Care Planning Process dated 11/06/2025 stated resident and /or resident's family will be invited to attend the interdisciplinary care plan meeting for comprehensive assessments.Resident #211 was admitted to the facility with diagnoses that included Schizophrenia, Diabetes Mellitus, and Seizure Disorder.The quarterly Minimum Data Set assessment dated [DATE] documented that Resident #211 was cognitively intact. The admission Minimum Data Set assessment dated [DATE] documented that Resident #211 felt it was very important for their family or friends to be involved in discussions about their care. On 07/01/2025, the Resident Manager of a group home that Resident #211 resided in prior to admission reported that the facility was refusing to discuss Resident #211's care with them or any other representative from the group home (Incident 646938).On 01/21/2026 at 11:12 AM, the Resident Manager from the group home that Resident #211 resided in was interviewed and stated that the group home acted as a representative for Resident #211. The Resident Manager stated that one of the contacts that the facility had for the Resident #211 was outdated as the person listed had retired and their phone was disconnected. The Resident Manager stated that the other contacts for Resident #211 were a Registered Nurse who worked at the group home, and the Executive Director from the group home. The Resident Manager stated that no one from the group home was invited to Resident #211's care plan meetings or involved in their care, despite wanting to be involved.On 01/23/2026 at 11:48 AM, the Executive Director from the group home who was listed as one of Resident #211's contact was interviewed and stated they would like to attend Resident #211's care plan meetings but was had not received an invitation from the facility. On 01/20/2026 at 10:04 AM, the Assistant Director of Nursing was interviewed and stated that a nurse on the evening shift had notified them on an unknown date that someone from Resident #211's group home had called the facility requesting information about Resident #211's care, but because they were not the group home employee listed on the resident's face sheet, they were not provided with information. The Assistant Director of Nursing stated that the Social Worker is typically the person who updates the list of contacts who can receive resident health information, and that they were not sure if the Social Worker was made aware of the group home's request for information. The Assistant Director of Nursing further stated that they did not personally communicate with Resident #211's representatives during the duration of their stay in the facility.On 01/20/2026 at 10:54 AM, Registered Nurse #4 was interviewed and stated that they were a Nurse Manager on Resident #211's unit. (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
	335271	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dumont Center for Rehabilitation and Nursing Care	676 Pelham Road New Rochelle, NY 10805

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #4 stated that they had not communicated with Resident #211's representatives during Resident #211's stay in the facility. They further stated that the Social Worker was responsible for inviting representatives to care plan meetings.On 01/21/2026 at 11:57 AM, Social Worker #1 was interviewed and stated that they are responsible for inviting residents and their representatives to care plan meetings. Social Worker #1 stated that resident representatives are only invited to initial, significant change, and discharge care plan meetings. Social Worker #1 stated that resident representatives are not invited to quarterly care plan meetings, and that if the resident refuses to attend, the Interdisciplinary Team meets without the resident or representative. Social Worker #1 stated that Resident #211's representatives was invited to and attended their discharge meeting but was unable to provide documented evidence that Resident #211's representatives were invited to Resident #211's initial or quarterly care plan meetings.On 01/22/2026 at 10:06 AM, the Director of Social Services was interviewed and stated that Social Worker #1 is responsible for inviting resident representatives to initial, significant change, and discharge care plan meetings. The Director of Social Services stated that representatives are not invited to quarterly care plan meetings, and that instead, information is shared with representatives when they come to visit residents on the unit. The Director of Social Services further stated that they were not aware that Resident #211's representatives wanted to be involved in their care plan meetings.On 01/23/2026 at 01:02 PM, the Director of Nursing was interviewed and stated that they were not aware that Resident #211's representatives felt like they were not being involved in their care planning. The Director of Nursing stated that they had not personally communicated with Resident #211's representatives during the duration of the resident's stay at the facility.10 NYCRR 415.11(c)(2) (i-iii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335271	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dumont Center for Rehabilitation and Nursing Care	676 Pelham Road New Rochelle, NY 10805

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews during the Recertification and Abbreviated (2680670) Survey, the facility did not ensure that all alleged violations involving abuse, neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the New York State Department of Health. This was evident for one (1) (Resident #35) of two (2) residents reviewed for Dignity out of 36 total sampled residents. Specifically, the Ombudsman reported to the Director of Nursing that Resident #35 alleged that a Nurse Practitioner verbally abused them. The incident was not reported to the New York State Department of Health.Cross Reference F610 Investigate/Prevent/Correct Alleged Violation The findings include: The undated facility's policy titled Patient / Resident Abuse documented it was the policy of the facility to initiate a report when there is an incident of or suspicion of physical abuse, sexual abuse, mistreatment or neglect of a resident(s), to the Office of Health Systems Management in accordance with New York State Public Health Law Section 2803d. The purpose of the policy was to be in compliance with the New York State Patient Abuse Reporting Law. The facility's policy titled Investigation protocol for Resident Abuse Cases dated 02/2005 documented that the staff nurse will initiate an incident report and will inform the supervisor. The supervisor will initiate investigation of the incident and will inform the Director of Nursing if there is a potential for abuse. The Director of Nursing will immediately review the case and determine if an initial investigation is needed and will inform the Administrator if it is a potential case of abuse. The Administrator will discuss with the Director of Nursing on the conclusion of internal investigation or the need to call the Department of Health. If the Department of health must be called, it must be done within 5 working days. Resident #35 had diagnoses of Paranoid Personality Disorder (distrust and suspicion of others), Major Depressive Disorder (persistent feelings of sadness or loss of interest), and Chronic Obstructive Pulmonary Disease (breathing is difficult due to air flow obstruction). The Quarterly Minimum Data Set assessment (a resident assessment tool) dated 11/13/2025 documented Resident #35 had intact cognition and required supervision to moderate assist with activities of daily living, bed mobility, manual wheelchair use, and ambulation.The Resident Occurrence Report Statement completed by Nurse Practitioner #1 dated 01/05/2026 documented they went to give Resident #35 a copy of their recent laboratory reports with Registered Nurse #4 who is the supervisor. Resident #35 was yelling and would not sign that they received a copy of their recent laboratory results. Resident #35 would not let them explain the results and was verbally abusive and disrespectful throughout the encounter on 12/26/2025.The Resident Occurrence Report Statement from Registered Nurse #4 who was the supervisor dated 01/05/2026 documented they accompanied Nurse Practitioner #1 to deliver requested laboratory results to Resident #35. After knocking and entering the room, Resident #35 became agitated stating they were woken up from their nap. Nurse Practitioner #1 apologized and began to explain the details of the laboratory results when Resident #35 interrupted and became verbally abusive towards Nurse Practitioner #1 and would not allow them to finish explaining the laboratory results. Resident #35 then yelled at Nurse Practitioner #1 to leave their room. Nurse Practitioner #1 asked Resident #35 to sign their copy for documentation that they received their request, but they refused. Resident #35 continued yelling at Registered Nurse #4 and Nurse Practitioner #1 to leave their room. The date of the counter was on 12/26/2025.There was no documented evidence Resident #35's allegation of abuse was reported to the New York State (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335271	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dumont Center for Rehabilitation and Nursing Care	676 Pelham Road New Rochelle, NY 10805

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Department of Health.On 01/15/2026 at 12:16 PM, Resident #35 was interviewed and stated Nurse Practitioner #1 is bad that they scream and yell at them.On 01/23/2026 at 12:07 PM, the Director of Nursing was interviewed and stated the Long-Term Care Ombudsman came to the facility on [DATE], the same day that Nurse Practitioner #1 and Registered Nurse #4 statements were gathered. The Ombudsman informed them that Resident #35 reported that Nurse Practitioner #1 was verbally abusive to them. The Director of Nursing stated that the abuse allegation was not reported to the Department of Health or investigated thoroughly because Registered Nurse #4 witnessed the encounter and Resident #35 tends to confabulate. The Director of Nursing also stated they concluded there was no evidence that Nurse Practitioner #1 was abusive to Resident #1 and instead it was actually the resident who was abusive to the Nurse Practitioner. On 01/23/2026 at 2:22 PM, the Administrator was interviewed and stated an allegation of verbal abuse must be fully investigated and is mandated to be reported to the Department of Health. 10 NYCRR 415.4(b)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335271	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dumont Center for Rehabilitation and Nursing Care	676 Pelham Road New Rochelle, NY 10805

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 - Few	Respond appropriately to all alleged violations. Based on observation, record review, and interviews conducted during the Recertification and Abbreviated Survey (iQIES Complaint 2680670), the facility failed to ensure that all alleged violations involving abuse were thoroughly investigated. This was evident for one (1) (Resident #35) of two (2) residents reviewed for dignity out of 35 total sampled residents. Specifically, on 01/05/2026, the facility received a report from the Ombudsman stating that Resident #35 alleged that Nurse Practitioner #1 verbally abused them. The facility failed to maintain evidence that the alleged violation of verbal abuse was thoroughly investigated. Cross Reference F609 Reporting of Alleged Violations The findings include:The facility's policy titled Investigation protocol for Resident Abuse Cases dated 02/2005 documented that the staff nurse will initiate an incident report and will inform the supervisor. The supervisor will initiate investigation of the incident and will inform the Director of Nursing if there is a potential for abuse. The Director of Nursing will immediately review the case and determine if an initial investigation is needed and will inform the Administrator if it is a potential case of abuse. The Administrator will discuss with the Director of Nursing on the conclusion of internal investigation or the need to call the Department of Health. If the Department of health must be called, it must be done within 5 working days. Resident #35 had diagnoses of Paranoid Personality Disorder (distrust and suspicion of others), Major Depressive Disorder (persistent feelings of sadness or loss of interest), and Chronic Obstructive Pulmonary Disease (breathing is difficult due to air flow obstruction).The Quarterly Minimum Data Set assessment (a resident assessment tool) dated 11/13/2025 documented Resident #35 had intact cognition and required supervision to moderate assist with activities of daily living, bed mobility, manual wheelchair use, and ambulation. The Resident Occurrence Report Statement from Nurse Practitioner #1 dated 01/05/2026 documented they went to give Resident #35 a copy of their recent laboratory reports with Registered Nurse #4 who is the supervisor. Resident #35 was yelling and would not sign that they received a copy of their recent laboratory results. Resident #35 would not let them explain results and was verbally abusive and disrespectful throughout the encounter on 12/26/2025.The Resident Occurrence Report Statement from Registered Nurse #4 who is the supervisor dated 01/05/2026 documented they accompanied Nurse Practitioner #1 to deliver requested laboratory results to Resident #35. After knocking and entering the room, Resident #35 became agitated stating they were woken up from their nap. Nurse Practitioner #1 apologized and began to explain the details of the laboratory results when Resident #35 interrupted and became verbally abusive towards Nurse Practitioner #1 and would not allow them to finish explaining the laboratory results. Resident #35 then yelled at Nurse Practitioner #1 to leave their room. Nurse practitioner #1 asked Resident #35 to sign their copy for documentation that they received their request, but they refused. Resident #35 continued yelling at Registered Nurse #4 and Nurse Practitioner #1 to leave their room. The date of the counter was on 12/26/2025.The facility only collected written statements from Nurse Practitioner #1 and Registered Nurse #4. The investigation did not include interviews and/or statements from Resident #35 who was the alleged victim, other residents on the unit, or other staff who might have potentially witnessed the alleged incident, and / or interactions or relationship between Nurse Practitioner #1 and other residents. The facility failed to present any conclusion and appropriate corrective action, if the allegation was verified, On 01/15/2026 at 12:16 PM, Resident #35 was interviewed and stated Nurse Practitioner #1 is bad, and yells and scream at them. On 01/23/2026 at 12:07 PM, the Director of Nursing was interviewed and stated the Ombudsman notified them on 01/05/2026 that Resident #35 reported that Nurse Practitioner #1 verbally abused them. The Director stated that statements were gathered from Nurse Practitioner #1 and Registered Nurse #4. The Director of Nursing stated that Registered Nurse #4 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335271	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dumont Center for Rehabilitation and Nursing Care	676 Pelham Road New Rochelle, NY 10805

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 - Few	witnessed the encounter, and that Resident #35 tends to confabulate. The Director of Nursing stated they concluded there was no evidence of abuse and it was actually Resident #1 who was abusive to the Nurse Practitioner. On 01/23/2026 at 2:22 PM, the Administrator was interviewed and stated that an allegation of verbal abuse must be fully investigated. 10 NYCRR 415.4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335271	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dumont Center for Rehabilitation and Nursing Care	676 Pelham Road New Rochelle, NY 10805

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the Recertification and Abbreviated (iQIES Complaint 646935) Survey, the facility failed to ensure that residents' comprehensive care plans were reviewed and revised by the interdisciplinary team periodically and after each comprehensive and quarterly review assessments. Additionally, the facility failed to ensure that a quarterly care plan meeting was held for each resident. This was evident for three (3) (Residents #35, #209 and #149) of 36 total sampled residents. Specifically, 1.) Resident #35's Abuse care plan was not reviewed and revised after each assessment, 2.) Resident #209, who had orders for intravenous hydration, had no care plan to address the intravenous fluid therapy, and 3.) Resident #149' quarterly care plan meeting was not held, as a result the resident was not able participate in the review and revision of their comprehensive care plan. The findings include: The facility policy and procedure titled Care Plan dated 11/06/2018 documented the comprehensive care plan will be reviewed and evaluated quarterly, annually, and when there is a significant change in the resident's condition, in conjunction with the Minimum Data Set Assessment. 1. Resident #35 had diagnoses of Paranoid Personality Disorder (distrust and suspicion of others), Major Depressive Disorder (persistent feelings of sadness or loss of interest), and Chronic Obstructive Pulmonary Disease (breathing is difficult due to air flow obstruction). The Quarterly Minimum Data Set assessment (a resident assessment tool) dated 11/13/2025 documented Resident #35 had intact cognition and required supervision to moderate assist with activities of daily living, bed mobility, manual wheelchair use, and ambulation. A Comprehensive Care Plan for abuse was established for Resident #35 on12/25/2023 and was last revised on 02/19/2024. There was no documented evidence that the Abuse Care Plan was evaluated or revised after 02/19/2024. On 01/22/2026 at 3:05 PM, Social Worker #1 was interviewed and stated that the abuse care plan must be updated quarterly and periodically if there is an occurrence. They stated they are not sure how the abused care plan was not updated after 02/19/2024. On 01/22/2026 at 3:27 PM, the Director of Social Services was interviewed and stated their department is responsible for evaluating and updating Resident #35's abuse care plan. The Director of Social Service stated they have a consultant who audits the care plans but recently the consultant was filling in for a social worker who was on vacation. 2. Resident #209 was admitted to the facility with diagnoses that included Seizure Disorder, Hypothyroidism, and Malignant Neoplasm of Brain. The admission Minimum Data Set, dated [DATE] documented moderately impaired cognition. A nurse's progress note dated 03/14/2025 at 12:40 PM documented that Resident #209 was weak and had poor oral intake. The resident was seen by the physician and ordered intravenous hydration. A physician's order dated 03/14/2025 included 0.45% Sodium Chloride Intravenous Solution at 50 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335271	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dumont Center for Rehabilitation and Nursing Care	676 Pelham Road New Rochelle, NY 10805

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cubic centimeter per hour every shift for hydration. The Medication Administration Record for March 2025 revealed 0.45% Sodium Chloride Intravenous Solution was administered from 03/14/2025 at 3:30PM shift to 03/17/2025 at 7:30 AM shift. There was no documented evidence that Resident #209's comprehensive care plan was reviewed and revised to reflect Resident #209's intravenous fluid therapy. On 01/22/2026 at 9:45 AM, the Director of Nursing stated the unit manager is responsible for revising and updating the care plans. 3. The facility's policy titled Resident Assessment Instrument and Care Planning dated 11/06/2025 documented resident and /or resident's family will be invited to attend the interdisciplinary care plan meeting for comprehensive assessments. Resident #149 was admitted to the facility with diagnoses that included Diabetes Mellitus and End Stage Renal Disease. The Quarterly Minimum Data Set, dated [DATE] documented that Resident #149 had intact cognition and that resident and the family participated in assessment and goal setting. On 01/15/2026 at 11:10 AM, Resident #149 was interviewed and stated they do not remember being invited or attending a care plan meeting. The Care Plan Meeting Schedule documented that Resident #149 was scheduled for a care conference on 12/09/2025 and 12/11/2025. However, there was no documented evidence in Resident #149's medical record that a care plan meeting was held. On 01/23/2026 at 9:52 AM, Social Worker #2 was interviewed and stated they were the social worker assigned to Resident #149 and was responsible for scheduling the care plan meeting. They stated that the resident had a care plan meeting scheduled for 12/09/2025 and 12/11/2025 but the meeting was not held because they did not realize that it was supposed to be a quarterly meeting. On 01/23/2026 at 11:59 AM, the Minimum Data Set Coordinator was interviewed and stated that Resident #149's last quarterly assessment was on 11/26/2025. They stated that the assessment schedule was sent by their department, but it is the social worker's responsibility to schedule the meeting. On 01/23/2026 at 12:46 PM, the Social Worker Director was interviewed and stated that Resident #149's care plan meeting may not have officially taken place, but they are in contact with the family if there are any concerns. On 01/23/2026 at 2:27 PM, the Director of Nursing was interviewed and stated that the Minimum Data Set department schedules the care plan meetings, and the Social Worker invites the residents and families. The Director of Nursing stated they were not aware that Resident#149's care plan meeting was not held as scheduled. 10 NYCRR 415.11(c)(2) (i-iii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335271	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dumont Center for Rehabilitation and Nursing Care	676 Pelham Road New Rochelle, NY 10805

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the Recertification and Abbreviated (iQIES Complaint 646935) survey, the facility failed to ensure that services provided met professional standards of quality. This was evident for one (1) (Resident #209) of four (4) residents reviewed for Discharge out of 36 total sampled residents. Specifically, Resident #209, who had no discharge order for intravenous therapy, was discharged home with an intravenous access device left in place. In addition, the resident was given discharge medications that belong to a different resident. Cross Reference: F694 Parenteral/Intravenous Fluids The findings are:The facility's policy and procedure titled Day of Discharge Protocol and Procedure dated 03/18/2025 documented that the licensed nurses are responsible for verifying discharge medications. The policy documented that medications being sent home must be verified by two (2) nurses for accuracy. The licensed nurse must remove all medical appliances as per physician's order prior to discharge, for instance intravenous line. Resident #209 was admitted to the facility with diagnoses include Seizure Disorder, Hypothyroidism and Malignant Neoplasm of Brain.The admission Minimum Data Set, dated [DATE] documented moderately impaired cognition.A physician's order dated 03/14/2025 documented Midline via IV national and 0.45% Sodium Chloride Intravenous Solution at 50 cubic centimeter per hour every shift at 7:30AM, 3:30PM, 11:30PM for nine (9) doses for hydration. The order was discontinued on 03/17/2025. Registered Nurse #13's note dated 03/17/2025 at 11:21 AM documented Resident #209 was discharged home with medication taken. Registered Nurse #12's note dated 03/17/2025 at 12:46 PM documented Resident #209 was discharged home with discharge medications. The Interdisciplinary Discharge summary dated [DATE] documented information related to Resident #209's care needs after discharge. There was no discharge plan or care instructions related to intravenous access device.The Occurrence Report Investigation dated 03/18/2025 documented on 03/18/2025, the facility received a call from a Hospice Nurse stating that Resident #209 was discharged home with an intravenous access device still in place and a blister pack of medication that did not belong to Resident #209. The Director of Nursing interviewed the unit staff and found that on 03/17/2025, Registered Nurse #13 was notified that Resident #209's transportation was waiting for the resident. Registered Nurse #13 disconnected Resident #209's intravenous line, without removing the intravenous access device. Resident #209 was also given discharge medications which included a blister pack that belonged to another resident. Registered Nurse Manager #12 visited Resident #209's home to retrieve another resident's blister pack of medication and removed Resident #209's intravenous device. Registered Nurse #13 and Registered Nurse #12 were no longer working at the facility, and were unable to be interviewedOn 01/22/2026 at 9:45 AM, the Director of Nursing was interviewed and stated they received a call from a Hospice Nurse on 03/18/2025 reporting that Resident #209 was discharged home with intravenous device access and a blister pack that did not belong to Resident #209. The Director of Nursing stated that Registered Nurse #13 and Registered Nurse #12 processed Resident #209's discharged on 03/17/2025. the Registered Nurses were interviewed and discovered that resident's intravenous line was disconnected but the access device was not removed. Registered Nurse Manager #12 was instructed to visit the Resident #209's home. Registered Nurse Manager #12 removed Resident #209's intravenous access device and another resident's blister pack was recovered and was returned to the facility. 10 NYCRR 415.11(c)(3)(i)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335271	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dumont Center for Rehabilitation and Nursing Care	676 Pelham Road New Rochelle, NY 10805

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the Recertification and Abbreviated (iQIES Complaint 646935) and Recertification survey, the facility failed to ensure that parenteral fluids were administered consistent with professional standards of practice. This was evident for one (1) of four (4) residents (Resident #209) reviewed for Discharge out of 36 total sampled residents. Specifically, Resident #209 did not receive appropriate care and services for their prescribed intravenous therapy. Medical records lacked ongoing monitoring of the resident's intravenous access device. The findings are:The facility's policy and procedure titled Intravenous Administration dated 12/01/2025 documented: 1) verify provider order: confirm medication/fluid, dose, volume, rate and frequency, review resident allergies. 2) prepare supplies 3) label intravenous bag, date/label intravenous tubing 4) set up intravenous/flow controller 5) start infusion 6) monitor infusion 7) discontinue intravenous: confirm with medical doctor that intravenous line is no longer needed, remove catheter, apply dressing and document removal, site condition.The facility's policy and procedure titled Intravenous Line Management and Dressing Change dated 11/12/2024 documented peripheral intravenous line is to provide proper care and maintenance to prevent external infection. Orders must be placed for all intravenous lines to include monitoring, monitoring every shift for sign, symptom of infection/infiltration, change dressing change 24 hours after insertion then every 7 days until removed or soiled. Tubing changes every 3 days during night shift.Resident #209 was admitted to the facility with diagnoses include Seizure Disorder, Hypothyroidism and Malignant Neoplasm of Brain. The admission Minimum Data Set, dated [DATE] documented moderately impaired cognition.The Physician Note dated 03/02/2025 documented Resident #209 noted bradycardia and to administer 0.9% Sodium Chloride intravenous at 75 cubic centimeter per hour for three doses to support hemodynamic stability.The Nursing Note dated 03/02/2025 at 5:54 PM documented Peripheral line order confirmation #189536. There was no documentation in resident's medical record of the date/time, site assessment, resident's tolerance and verification of the intravenous insertion. The Physician Order initiated 03/02/2025, discontinued 03/04/2025 documented 0.9% Sodium Chloride Intravenous Solution at 75 cubic centimeter per hour intravenously every shift for three (3) doses for hydration.The Medication Administration Record for 0.9% Sodium Chloride Intravenous Solution documented two (2) administrations recorded on 03/02/2025 during 11:30PM to 7:30AM shift and on 03/03/2025 from 3:30PM to 11:30PM shift.There was no documented evidence that an administration or assessment of the intravenous therapy was conducted on 03/03/2025 during 7:30AM to 3:30PM shift.In addition, there was no documented evidence that Resident #209 was evaluated to determine if intravenous access device should be maintained or removed upon completing intravenous fluid therapy on 03/03/2025.The Nursing Note dated 03/04/2025 at 8:09 PM documented peripheral intravenous line at left hand was dislodged and bleeding noted. Line removed, cleaned and dressing applied.The Nursing Note dated 03/14/2025 documented Resident #209 plan to start 0.45% Sodium Chloride for hydration. Author tried to insert it twice, unsuccessful. Ordered IV National Resident's family was called and updated.The Physician Order initiated 03/14/2025 discontinued 03/17/2025 documented Midline via IV national and 0.45% Sodium Chloride Intravenous Solution at 50 cubic centimeter per hour every shift for 9 doses for hydration.There was no documentation of the midline placement to include date/time, site assessment, resident's tolerance and verification of the device insertion.The Nursing Note dated 03/14/2025 at 11:39 PM documented Resident #209 started intravenous fluid 0.45% Sodium Chloride for hydration.The Physician Note dated 03/15/2025 documented Resident #209 seen for hypernatremia, continue intravenous 0.45% Sodium Chloride for gradual correction of Sodium levels. Monitor closely for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335271	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dumont Center for Rehabilitation and Nursing Care	676 Pelham Road New Rochelle, NY 10805

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sign/symptom of fluid overload.The Medication Administration Record for March 2025 revealed 0.45% Sodium Chloride Intravenous Solution was administered from 03/14/2025 at 3:30PM to 11:30PM shift to 03/17/2025 at 7:30AM to 3:30PM shift.Review of the Nursing Notes from 03/15/2025 to 03/17/2025 revealed nursing assessment and monitoring were not consistently documented. Nursing Note dated 03/15/2025 at 12:35PM documented peripheral intravenous line in the left arm. The Nursing Notes dated 03/15/2025 at 8:24 PM, dated 03/16/2025 at 8:59 PM documented peripheral line in the left hand. The Nursing Notes dated 03/16/2025 at 6:37 AM, dated 03/16/2025 at 3:25 PM and dated 03/17/2025 at 6:34 AM documented midline on the left upper arm.On 01/20/2026 at 9:56 AM, Registered Nurse #10 was interviewed and stated that Resident #209 had peripheral line placed on left hand for intravenous therapy as per reviewing the record. Resident #209 received the infusion continuously for three shifts. Nurses are responsible for monitoring infusion and assessing the intravenous site every shift. Registered Nurse #10 stated they cannot locate the midline placement documentation for intravenous therapy and could not explain why there was no documentation in the medical record.On 01/23/2026 at 10:19 AM, Nurse Practitioner #1 was interviewed and stated that the provider assesses and determine the resident's need for intravenous therapy. Once it is determined, the intravenous is ordered and placed intravenous access device either via peripheral or midline. If intravenous order is to be infused continuously then the order is written with type of fluid, rate, duration. The duration is written in the electronic medical record as 3 doses = 3 shifts = 24 hours. Nurse Practitioner stated they have been ordering in this way and were not aware of any issues. Nurse Practitioner stated once resident completed the intravenous infusion, provider should be notified. They stated that the provider will re-evaluate/determine the next treatment plan or will have the intravenous access device removed.On 01/22/2026 at 9:45 AM, Director of Nursing stated Resident #209 was noted bradycardia and started intravenous therapy for hydration from 03/02/2025 to 03/03/2025. Resident #209 had another intravenous therapy ordered from 03/14/2025 to 03/17/2025 after laboratory results showed elevated sodium level. They stated that a Registered Nurse attempted to insert the peripheral line but was unsuccessful so an order for midline placement was made which was inserted by an intravenous vendor. The Director of Nursing stated there was no documentation found in the medical record that showed that intravenous access placement was made on 03/02/2025 and on 03/14/2025. The Director of Nursing stated intravenous placement, or insertion must be documented and along with an ongoing assessment of the site infusion. 10 NYCRR 415.12 (k)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335271	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dumont Center for Rehabilitation and Nursing Care	676 Pelham Road New Rochelle, NY 10805

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review, and interviews, the facility failed to ensure that food was served at an appetizing temperature during meal service. This was evident for two (2) of six (6) units observed during Dining Observation. Specifically, foods served during lunch meal service were not maintained at palatable and appetizing temperatures. The findings are:The facility's policy and procedure titled Food Temperatures reviewed 01/2026 documented all hot food items must be served to the resident at the temperature of at least 140 degrees Fahrenheit at the time of resident received the food.The Meal Delivery Schedule Sheet dated 12/07/2025 documented lunch for Unit 1 was served at 11:55 AM and Unit 2 North was served at 12:10 PM.On 01/20/2026 at 11:38 AM, Test trays were requested for 1st floor and 2nd floor. On 01/20/2026 at 11:50 AM, Food truck was delivered to 1st floor, and staff distributed meal trays to residents in the rooms until 12:10 PM.On 01/20/2026 at 12:10 PM, Test trays were conducted with Food Service Director on 1st floor. It revealed the following for Regular Diet Tray: baked potatoes at 110 degrees Fahrenheit, turkey chili at 105 degrees Fahrenheit, green beans at 90 degrees Fahrenheit. Puree Diet Tray: mashed potato at 130 degrees Fahrenheit, puree green beans at 125 degrees Fahrenheit, puree turkey at 122 degrees Fahrenheit. On 01/20/2026 at 12:15 PM, Food truck arrived on 2nd floor and staff delivered meal trays to residents in the rooms until 12:39 PM. On 01/20/2026 at 12:39 PM, Test trays were conducted with Food Service Director on 2nd floor and revealed the following for Puree Diet Tray: puree green beans at 125 degrees Fahrenheit, puree turkey at 124 degrees Fahrenheit, mashed potato at 130 degrees Fahrenheit. Regular Diet Tray: baked potato at 123 degrees Fahrenheit, green beans at 116 degrees Fahrenheit, turkey chili with beans at 122 degrees Fahrenheit. On 01/21/2026 at 12:35 PM, the Food Service Director was interviewed and stated that hot foods should be served above 140 degrees Fahrenheit for hot foods to be palatable. The Food Service Director acknowledged that hot foods were not maintained at the appropriate temperature range for hot foods served on 01/20/2026. The Food Service Director stated food temperature issues were brought up in the past and was addressed by replacing the equipment and conducting temperature audit every month. There were no further issues reported since then, so they were not aware of this issue.On 01/21/2026 at 2:30 PM, the Administrator was interviewed and stated that they will assess the meal service process and find the solution to ensure residents are served hot foods.10 NYCRR 415.14(d)(1)(2)