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	05/01/2024

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45478 Based on observation and interviews conducted during the recertification survey from 4/24/24 to 5/1/24, the facility did not maintain a safe, clean, comfortable and home-like environment for 1 of 1 resident's rooms (Resident #44/Unit 3North room [ROOM NUMBER]) reviewed for environment. Specifically, Resident #44 was in their room and a maintenance staff was repairing the flooring in their room with glue and there was an odor observed. On 4/24/24 at 2:08 PM Resident # 44 was observed lying in bed in their room while maintenance staff was repairing the flooring in their room. The bed was pushed diagonal to access the flooring that the maintenance staff was attempted to reglue, and the glue had an odor. On 4/25/24 at 2:10 PM Licensed Practical Nurse, Staff # 7, was asked if the resident should be in the room while repairs are being done in the room and Staff #7 stated the resident should not be in the room, but resident had an episode of emesis, so they did not want to remove them from room. 04/25/24 02:11 PM, Maintenance Worker, Staff #6, was asked if a resident should be in the room while doing repairs the worker stated the glue is non odorous. When asked if they informed the nursing staff, they would be repairing floor in Resident #44 room, they stated no. On 4/25/24 at 2:13 PM, Registered Nurse Unit Manager, Staff #5 stated if maintenance is doing repairs in the resident's room, the resident should not be in the room. Registered Nurse Unit Manager stated the resident should have been removed but resident was not feeling well today. Registered Nurse Unit Manager stated they were not informed maintenance was going to repair the floor. On 4/25/24 at 2:20 PM, Maintenance Director was asked if residents should be in the room during repairs and they stated no unless there was a special circumstance. This writer asked specifically about repairing the flooring, and they stated, absolutely not. On 4/26/24 at 8:55 AM, Administrator stated that they were made aware this writer observed maintenance staff repairing flooring while resident was in the room. Administrator stated this was not the policy and that they absolutely do not do repairs while a resident is in the room. Administrator stated the maintenance staff was written up as a result. 10 NYCRR 415.29(j)(1)

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

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

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F 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. 45478 Based on observations, record review and interview during the recertification and abbreviated surveys (NY00333316), the facility did not ensure that all alleged violations involving abuse and neglect were reported within 2 hours to New York State Department of Health (NYSDOH) for 1 of 2 residents reviewed for abuse. Specifically, Resident #94's family informed the facility of an allegation of sexual abuse on 2/10/24 and facility reported to New York State Department of Health (NYSDOH) on 2/11/24. Findings include: Resident #94 was admitted to facility with diagnoses including diabetes, muscle weakness, difficulty walking, and a displaced comminuted fracture of shaft of right femur. The Admission Minimum Data Set (MDS, an assessment tool) dated 1/31/24 documented Resident #94 had moderately impaired cognition and no behavioral symptoms. Facility Accident/Incident investigation dated 2/10/24 documented that a family member of Resident #94 called the Nursing Supervisor on 2/10/24 around 4 PM, and reported that Resident #94 told them they were molested. Resident #94 stated a man entered their room and and sexually assaulted them at midnight. Resident #94 was unable to describe what staff looked like or what they were wearing. The family and police were notified, the police came and the family member declined sending Resident #94 to the hospital. Review of the incident submission report revealed the incident was reported to the New York Department of Health on 2/11/24 at 11:21 AM. When interviewed on 4/30/24 at 12:04 PM, the Director of Nursing stated they called Administrator specifically to review incident and whether it needed to be reported right away as they were not working that day. The Director of Nursing stated the Administrator informed them they looked at the guidelines and because there was no injury or harm, they could report it within 24 hours. When interviewed on 5/01/24 at 1:43 PM, the Administrator stated they reviewed the incident, and did not feel it was harm and did not need to report with 2 hours and could be done in 24 hours. They stated it only needed to be reported in 2 hours if there was harm. 10NYCRR 415.4 (b)(2)(3)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49364 Based on record review and interviews conducted during the recertification survey from 4/24/24 through 5/1/24, the facility did not ensure a Minimum Data Set Discharge Assessment was completed and transmitted for 1 of 2 residents (Resident #150) reviewed for discharge. Specifically, Resident #150 was discharged from the facility on 2/16/24 and the Minimum Data Set Discharge Assessment had not been done at time of survey. The findings include: The facility policy and procedure titled Resident Assessment Instrument issued 10/1/2023, documented the Resident Assessment Instrument (RAI) is used, in accordance with specified format and timeframe's, in conducting comprehensive assessments. In addition, the assessment coordinator is responsible for ensuring the Interdisciplinary Team complete timely residents' assessments and reviews in accordance with CMS RAI Version 3.0 Manual, Chapter 2 assessment schedules: 1. Admission within 14 days of residents' admission to the facility. 2. Quarterly review at least 92 days. 3. Residents' discharge within 14 days after discharge date . The Minimum Data Set (MDS) records of the following resident were reviewed and revealed that a Quarterly assessment were not completed within the Assessment Reference Date (ARD) plus 14 days or 92 days from the last Quarterly Assessment. Resident #150 was admitted to the facility on [DATE] with diagnoses including asthma, glaucoma, and hyperlipidemia. Review of the Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact and received physical and occupational therapy. A nursing progress note dated 2/16/24 at 10:52 AM documented the resident was discharged to home and left the facility with their spouse. Further review of Resident #150's electronic medical record revealed the Minimum Data Set Discharge Assessment was incomplete and was not submitted. On 4/30/24 at 2:39 PM, during an interview Staff #14 (Minimum Data Set coordinator) stated Resident #150's Comprehensive Minimum Data Set 5 day assessment was completed on 12/1/23 that was the last assessment done. They reviewed the record and stated they missed completing the Minimum Data Set Discharge Assessment. On 5/1/24 at 10:59 AM, an interview the Director of Nursing stated they were unaware Resident #150 Minimum Data Set Discharge Assessment was not completed and the Minimum Data Set (MDS) department was a separate department from nursing. 10 NYCRR 415.11(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45478 Based on observation, record review, and interviews during a recertification survey (4/24/2024-5/1/2024), the facility did not ensure each resident received care, consistent with professional standards of practice, to prevent pressure ulcers for 1 of 13 (Resident #8) residents reviewed for pressure ulcers. Specifically, Resident #8 had care plan interventions and physicians order recommendations to offload heels with heel booties while in bed; however, the resident was observed in bed with their heels resting directly on the mattress and there was no pillow on the mattress for the resident's feet. Findings include: Resident #8 was admitted to the facility on [DATE] with diagnoses including Non-Alzheimer's Dementia, muscle weakness, and schizophrenia. The 3/20/24 Quarterly Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) of 3, indicating the resident had severe cognitive deficit. The MDS documented the resident was at risk for pressure ulcers. A Pressure Ulcer Care Plan created on 10/23/16 documented a goal that the resident will not develop ulcers for 3 months. Interventions updated 1/18/23 documented bilateral heel booties in bed. There was no documentation in the care plan that the resident refused to have their heels offloaded. There was no documented evidence of refusal to wear heel booties. The April 2024 Certified Nursing Assistant Instructions documented to offload the resident's bilateral heels with booties while they are in bed. The resident was observed in bed on 4/24/24 at 10:28 AM, 4/25/24 at 11:10 AM, 4/26/24 at 9:06 AM and 4/30/24 at 10:08 AM. The resident's feet were not being supported by any pillows and their heels were not offloaded from bed with bilateral heel booties. During an interview on 4/30/24 at 10:44 AM, Certified Nurse Assistant (Staff #8) stated to their knowledge the resident was not using heel booties. Stated they were not aware resident was to wear heel booties. Stated they have not seen the heel booties on resident while in bed and have not had to remove them when doing care. During an interview on 4/30/24 at 10:49 AM, Licensed Practical Nurse (Staff #7) was asked if the resident was supposed to wear heel booties. Staff #7 stated, the resident did not have an order for heel booties. Staff #7 was asked how they are informed when a new order is added, they stated it is added to the 24-hour report and then nursing will carry out the order. Staff #7 stated they were not sure not sure if they were off and missed the report that day. 10 NYCRR 415.12(c)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49255 Based on observations, record review and interviews during the recertification survey conducted from 4/24/2023 to 5/1/2024 the facility did not ensure that they store, prepare, distribute, and serve food in accordance with professional standards for food service. Specifically, sanitary conditions were not maintained in the main kitchen area. In the dishwasher area, the blue cup racks, which the kitchen staff claimed as clean racks were stored on the floor then later were picked up and combined with other clean racks for further use. The findings are: The facility policy and procedures titled Storage of Utensils, Trays, Racks to prevent contamination documented that clean equipment, racks and utensils will be stored in a clean, dry location in a way that protects them from contamination by splashes and dust. During the initial tour of the kitchen observation on 4/24/24 at 10:02 AM the Dietary Aide was loading blue cup racks on the cart next to dry and clean area of the dishwasher and moved them away. Next, the Dietary Aide picked up two blue cup racks from the floor, which were stored under the dishwasher transporter and combined them with other racks that were taken from the top of transporter and moved them away. During an interview on 4/24/24 at 10:02 AM the Director of Dietary Service stated that the Dietary Aide was loading clean blue cup racks from the top of dishwasher on the cart for further use. The surveyor asked the Director of Dietary Service if it was correct to combine the clean racks and the one that were picked up from the floor for further use. The Director of Dietary Service stated that it was not the correct action. The clean racks were contaminated and cannot be used. 10 NYCRR 415.14(h)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666 REVISED 6/26/24 IDR Based on observations, record review and interviews during a recertification survey from 4/24/24-5/1/24, the facility did not ensure that an infection prevention plan was implemented for identifying, tracking, and monitoring infections, communicable diseases, and outbreaks. Specifically, 1) Clostridium Difficile infections were not documented on the infection line list at readmission from the hospital for 1 of 3 Residents (Resident #101) until 5 days later, 2) measures to prevent the spread of Clostridium Difficile were not implemented to include a private room, and 3) Resident #113's ventilator tubing was not changed within parameters and was 5 days past due. The findings are: The facility undated policy for Infection Control, documented personnel must be aware of and alert to problems and potential infection control problems throughout the facility and protect residents from infection with constant surveillance of the environment and all who enter it. The Centers for Disease and Prevention guidance titled, 'How Can CDI (Clostridium Difficile) be prevented in hospitals and other Healthcare Settings?' Documented: use Contact Precautions with known or suspected Clostridium Difficile and place these residents in private rooms. If private rooms are not available, they can be placed in rooms (cohorted) with other CDI patients. The facility policy Clostridium Difficile, dated 5/2009, documented a private room is indicated. Residents with C. difficile may be cohorted. 1. Resident #101 had diagnoses of sepsis, major depressive disorder, and atrial fibrillation. The Minimum Data Set, (an assessment tool) dated 4/3/24 documented the resident did not have cognitive impairment, was hearing impaired and needed assistance from staff for activities of daily living. Resident #101 was ventilator dependent and was readmitted from the hospital on 4/21/24 after treatment for sepsis secondary to Clostridium Difficile. Resident #101's physician orders dated 4/21/24 document contact precautions for Clostridium Difficile for 10 days and Vancomycin (antibiotic) oral suspension via gastrostomy tube every 6 hours for 40 doses. An observation was made on 4/25/24 at 02:02 PM on the 4th floor unit. Resident #101 was in their room with Resident #27 (roommate) who was also ventilator dependent, and all curtains were pushed back. A review of Resident #27's medical record revealed a diagnoses of respiratory failure and ventilator dependence. Resident #27's Minimum Data Set, dated dated dated [DATE] documented the resident was dependent on staff for all care and was incontinent of bowel and bladder. There was no documented evidence of active Clostridium Difficile infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/25/24 at 02:00 PM, Staff #17 (Registered Nurse) stated Resident #101 returned from the hospital with Clostridium Difficile infection and was placed back in the same room they were in before going to the hospital. Staff #17 stated they did not know how the decision was made to keep Resident #101 in the same room with Resident #27 who did not have Clostridium Difficile. During an interview on 4/26/24 at 1:15 PM, the Infection Preventionist was asked for their line list for all residents with Clostridium Difficile. They stated there were no active cases in the building. The Infection Preventionist looked in the computer and named three residents who had been the last cases and Resident #101 was not one of them. They stated in morning report they usually found out about infections and residents that have been started on antibiotics and that was how they started tracking infections. The Infection Preventionist stated when Resident #101 was readmitted , they were not aware the resident had Clostridium Difficile and the resident received antibiotics for 5 days before they had knowledge about it. They stated they were not aware that a private room was indicated to prevent the spread of infection. During an interview on 4/26/24 at 2:35 PM, Physician #2 stated they performed the readmission assessment from the hospital for Resident #101 and were aware of the resident's Clostridium Difficile infection at morning report the day after readmission. They stated they were aware of the indication for a private room and did not think about it at the time and should have put Resident #101 in a private room. During a second interview with the Infection Preventionist on 5/1/24 at 12:00 PM, they stated they were informed by the unit managers about Resident #101 having Clostridium Difficile infection at morning report but forgot about it and that was why the infection tracking had not been started. 2. The facility policy and procedures titled Infection Prevention and Control program documented the following policies and procedures are designed to control and reduce the risk of nosocomial infections due to respiratory care equipment and procedures. Disposable ventilator circuits will be changed and dated every 2 weeks and when visibly soiled or mechanically malfunctioning. Resident #113 was admitted to the facility with diagnoses including persistent vegetative state, and acute and chronic respiratory failure. The Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had severely impaired cognition and was dependent with functional abilities. The physician order dated 4/3/24 documented ventilator settings as AC Mode: VT 450, respiratory rate 16 FIO2 40%, PEEP +5 and to monitor log vent parameters every 6 hours. During observations on 4/24/24 at 12:51 PM and 4/25/24 at 9:46 AM the ventilator circuit was observed dated 4/5/24. During an interview on 4/25/24 at 9:46 AM Director of Respiratory stated per policy they changed ventilator tubing every two weeks. The Director of Respiratory observed the tubing and stated it was dated 4/5/24 and should have been changed on 4/19/24. 10 NYCRR 415.19(b)(1) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49255