STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335595	A. Building B. Wing	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dunkirk Rehabilitation & Nursing Center	447 449 Lake Shore Drive West Dunkirk, NY 14048

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 39086 Based on interview and record review conducted during the Standard survey completed on 3/11/22, the facility did not inform the resident's representative of a change in physical status and a transfer to the hospital for one (Resident #34) of one resident reviewed for notification of change. Specifically, the resident's representative was not notified when Resident #34 tested positive for COVID -19 on 12/31/22 and was subsequently transferred to the hospital on 1/6/22. The findings are: Review of the facility policy and procedure (P/P) titled Change in Status Notification dated 9/2021 documented it is the facilities policy that in accordance with State and Federal Regulations; notification to the resident, and the resident's representative(s), consistent with his/her authority, will be made when there is an a significant change in the resident's physical, mental or psychological status in either life threatening conditions or clinical complications; a need to alter treatment significantly or to commence a new form of treatment; or a decision to transfer the resident from the facility. 1. Resident #34 had diagnoses including Down syndrome, Alzheimer's disease, and dementia. The Minimum Data Set (MDS-resident assessment tool) dated 1/24/22 documented Resident #34 sometimes understood, understands and was severely cognitively impaired. During an interview on 3/8/22 at 1:49 PM, Resident #34's responsible party stated the resident tested positive for COVID-19 in December of 2021 and was sent to the hospital in January 2022 and they were not notified. Review of the Progress Notes dated 12/31/21 completed by Licensed Practical Nurse (LPN) #2 documented Resident #34 tested positive for COVID, had sinus congestion with rhinorrhea (runny nose), an occasional nonproductive cough (NPC) and general malaise (general feeling of discomfort, illness, or uneasiness). The resident was to be monitored and fluids encouraged. The resident's vital signs were stable. Review of the Progress Notes dated 1/6/22 completed by LPN #3 documented a late entry: resident was having low O2 (oxygen) level and was told by DON (Director of Nursing) to send to ER (emergency room). (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Notes from 12/31/22 and 1/6/22 revealed there was no documented evidence that the responsible party was notified of either event. During an interview on 3/10/22 at 1:03 PM, LPN #2 stated I did not call the family to tell them the resident tested positive for COVID. I was told the Administrator calls everybody when someone tests positive. I did not know at the time it was a 'general' robo call to everyone and not specifically to the residents family. During an interview on 3/10/22 at 1:06 PM, Regional Registered Nurse (RNS) #1, Interim Director of Nursing (DON) stated we should notify a family with any change of status. There should be a family notification when a resident becomes COVID positive and when they are sent to the hospital. Staff should document this in the medical record. I do not see any family notifications for either of these two changes of status. 415.3(e)(2)(ii)(b)(d)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 39086 Based on observation, interview and record review conducted during an Extended Standard survey completed on 3/11/22, the facility did not ensure each resident was free from exploitation (taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion) for one (Resident #18) of two residents reviewed. Specifically, Certified Nurse Aide (CNA) #4 requested and accepted money from Resident #18 to provide the resident with sexually explicit photos. The finding is: The facility policy and procedure (P&P) titled Accident/Incident - Investigation & Reporting dated 6/2021 documented all accidents and incidents occurring within and related to the facility will be investigated. The investigation should rule out or confirm abuse, exploitation or neglect. The State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities revised 11/22/17 documents facility staff are in a position that may be perceived as one of power over a resident. As such, staff may be able to manipulate or unduly influence decisions by the resident. Staff must not accept or ask a resident to borrow personal items or money, nor should they attempt to gain access to a resident's holdings, money, or personal possessions through persuasion, coercion, request for a loan, or solicitation. A resident's apparent consent is not valid if it is obtained from a resident lacking the capacity to consent, or consent is obtained through intimidation, coercion or fear, whether it is expressed by the resident or suspected by staff. 1. Resident #18 had diagnoses that included post traumatic stress disorder (PTSD), anxiety, and depression. The Minimum Data Set (MDS, a resident assessment tool) dated 1/25/22 documented Resident #18 understands, was understood and cognition was not assessed. The 11/17/21 MDS documented Resident #18 was cognitively intact. During intermittent observations 3/7/22 through 3/11/22, Resident #18 was alert, oriented, and cognitively intact. The facility Disciplinary Action Report dated 8/20/21 and signed by CNA #4 documented the following reasons for action: Sexual or other unlawful harassment; Immoral conduct that would be widely regarded as improper or inappropriate in a work group; Soliciting loans/kickbacks from residents, families or vendors; Willful violation of Corporate Compliance Program - Code of Conduct or Ethics Policy; and Other extreme instances of improper conduct not specifically listed. Additionally, the reason for action documented CNA #4 provided resident with sexually explicit photos, and CNA #4 requested and accepted money from Resident #18. The report also documented the pornographic photos were on file. The Human Resources status update dated 8/20/21 documented on 8/20/21 CNA #4 was asked if they would like union representative present for the disciplinary action report that was being presented to them. CNA #4 was informed that this was regarding the indecent and inappropriate material involving them. CNA #4 verbally refused to have representation and signed off on the disciplinary written report. At that time, CNA #4 stated that things were bad at their home, and they knew their actions were wrong and wanted to leave rather than proceed with any further discussion. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an email dated 8/23/21 at 10:23 AM to the Director of Nursing provided by the facility revealed a text message chain from CNA #4 to LPN #5 that documented CNA #4 sent pictures to Resident #18 for cash due to having no money. During an interview on 3/10/22 at 11:16 AM, Resident #18 stated they received sexually explicit photos of CNA #4 on their cell phone, and that they were aware CNA #4 was having domestic and financial problems. During an interview on 3/10/22 at 12:11 PM, the Administrator stated CNA #4 was terminated for the moral/ethical issues of sending sexually explicit photos of themselves to a resident. 415.4(b)

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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. 39086 Based on observation, interview and record review conducted during an extended standard survey completed on 3/11/22, the facility did not ensure that all alleged violations including abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for one (Resident #18) of two residents reviewed. Specifically, Certified Nurse Aide (CNA) #4 requested and accepted money from Resident #18 to provide the resident with sexually explicit photos that was not reported to the New York State Department of Health (NYS DOH) as required within the two-hour time frame. The facility policy and procedure (P&P) titled Abuse, Investigation & Reporting dated 10/1/2019 documented all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations). An alleged violation of abuse, neglect, exploitation or mistreatment will be reported immediately, but not later than two hours if the alleged violation involves abuse or has resulted in serious bodily injury to the State licensing/certification agency responsible for surveying/licensing the facility. The State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities revised 11/22/17 documents facility staff are in a position that may be perceived as one of power over a resident. As such, staff may be able to manipulate or unduly influence decisions by the resident. Staff must not accept or ask a resident to borrow personal items or money, nor should they attempt to gain access to a resident's holdings, money, or personal possessions through persuasion, coercion, request for a loan, or solicitation. A resident's apparent consent is not valid if it is obtained from a resident lacking the capacity to consent, or consent id obtained through intimidation, coercion or fear, whether it is expressed by the resident or suspected by staff. Refer to F 602 Freedom from Misappropriation/ Exploitation scope/severity =D 1. Resident #18 had diagnoses that included post-traumatic stress disorder (PTSD), anxiety, and depression. The Minimum Data Set (MDS, a resident assessment tool) dated 1/25/22 documented Resident #18 understands, was understood, and cognition was not assessed. The 11/17/21 MDS documents Resident #18 was cognitively intact. During intermittent observations 3/7/22 through 3/11/22, Resident #18 was alert, oriented, and cognitively intact. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Disciplinary Action Report dated 8/20/21 and signed by CNA #4 documented the following reasons for action: Sexual or other unlawful harassment; Immoral conduct that would be widely regarded as improper or inappropriate in a work group; Soliciting loans/kickbacks from residents, families or vendors; Willful violation of Corporate Compliance Program - Code of Conduct or Ethics Policy; and Other extreme instances of improper conduct not specifically listed. Additionally, the reason for action documented CNA #4 provided resident with sexually explicit photos, and CNA #4 requested and accepted money from the resident. Review of the NYS DOH Automated Complaint Tracking System (ACTS, software that logs and tracks nursing home complaints) 8/1/21 through 8/31/21 revealed the solicitation of Resident #18, by CNA #4 was not reported. During an interview on 3/11/22 at 8:55 AM, the Director of Nursing (DON) stated they had spoken with the Corporate Quality Assurance (QA) Nurse and the Corporate DON who had stated the incident was not reportable to the NYS DOH secondary to the exchange of money for sexually explicit pictures was consensual between CNA #4 and Resident #18. During an interview on 3/11/22 at 9:42 AM, the Administrator stated the incident was not reported to the NYS DOH secondary to Resident #18 and CNA #4 were able to consent to the transaction, and that the photos were not taken inside the building. 415.4(b)(4)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39086 Based on record review and interviews conducted during an Extended Standard survey started on [DATE] and completed on [DATE], the facility failed to initiate Cardiopulmonary Resuscitation (CPR) to an unresponsive resident who had Full Code status for one (Resident #86) of three residents reviewed. Specifically, on [DATE] Resident #86 was found unresponsive by Certified Nurse Aide (CNA #1) at approximately 4:30 AM. At that time, CNA #1 notified Licensed Practical Nurse (LPN #1). LPN #1 observed Resident #86, who was unresponsive without a pulse, respirations, or blood pressure and had bubbling excretions from their mouth. LPN #1 failed to initiate a Code Blue (emergency response) to summon additional help, failed to activate the 911 (EMS) system, and failed to provide CPR efforts for a resident who was a full code. LPN #1 instead contacted the Director of Nursing (DON) by telephone, without response. LPN #1 stated during interview it was their professional judgment to not perform CPR. LPN #1 did not provide documented clear evidence to support clinical signs for The American Heart Association (AHA) guidelines of irreversible death at the time the resident was observed unresponsive. This resulted in actual harm to Resident #86's health and safety with the likelihood to affect all residents with full code status in the facility that is Immediate Jeopardy and Substandard Quality of Care. There were 13 full code residents in the facility. The finding is: The facility policy and procedure (P&P) dated ,d+[DATE], titled Cardiopulmonary Resuscitation (CPR) & Emergency Response Team documented CPR will be performed on those residents who are found to be unresponsive, without a Do Not Resuscitate (DNR) order in place that are determined not to be clinically dead. CPR certified nursing staff will perform CPR under these circumstances. If the resident's wishes are to receive CPR, it will commence immediately. Any staff member that discovers an unresponsive resident will immediately overhead page Code Blue and the location 3 times. Retrieve the residents' chart to verify CODE status from the residents MOLST/Advance Directives form(s) and current medical orders. Call 911; unless the Advance Directives indicate no hospitalization . The State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities revised [DATE] documented the American Heart Association (AHA) publishes guidelines every five years for CPR and Emergency Cardiovascular Care (ECC). These guidelines reflect global resuscitation science and treatment recommendations. The AHA urges all potential rescuers to initiate CPR unless a valid Do Not Resuscitate (DNR) order is in place; obvious clinical signs of irreversible death (e.g., rigor mortis (stiffening of the joints and muscles of a body a few hours after death), dependent lividity (reddish-blue discoloration of the skin resulting from the pooling of blood in the blood vessels in the lower lying parts of the body in the position of death), decapitation, transection, or decomposition) are present; or initiating CPR could cause injury or peril to the rescuer. 1. Resident #86 was admitted with diagnoses that included dementia, Parkinson's disease, and hypertension (HTN). The Minimum Data Set (MDS, a resident assessment tool) dated [DATE] documented Resident #86 had severe cognitive impairments and did not have a DNR order. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The undated comprehensive care plan documented Resident #86's Advanced directive wishes will be honored through discharge, and documented interventions the resident had full code status. The facility Order Summary Report documented active orders as of [DATE] that included Resident #86 was a full code. The Progress Note dated [DATE] at 7:15 AM written by Physician #1 documented Resident #86 was pronounced deceased at 7:00 AM. Resident #86 was pulseless with no neurological function. The Progress Note dated [DATE] at 7:30 AM written by LPN #1 documented Resident #86 was found unresponsive on last rounds, cold to the touch and cyanotic (bluish discoloration of the skin resulting from poor circulation or inadequate oxygenation of the blood). The same note documented DON notified and MD notified and came in to pronounce dead. There was no documented evidence that Resident #86's vital signs were undetectable and no documented evidence of obvious clinical signs of irreversible death. Additionally, there was no documented evidence LPN #1 initiated code blue response or activated the 911 (EMS) system. The Daily Nurse Staffing Form dated [DATE] documented a resident census of 30. Review of the facility Daily Census document dated [DATE] provided by the facility identified there were 13 full code residents in the facility. Review of the nursing staff schedule dated [DATE] documented that LPN #1 was the sole nurse scheduled for the night shift and CNA #1 was the sole aide scheduled for the night shift. Additional review revealed there was no RN scheduled for any shift (days, evenings, and nights). The schedule did not document who should be contacted when there was no RN on site. During a telephone interview on [DATE] at 6:31 AM, CNA #1 stated when they entered Resident #86's room for last rounds (approximately 4:30 AM) Resident #86 was unresponsive and CNA #1 alerted LPN #1. During a telephone interview on [DATE] at 7:52 AM, LPN #1 stated they had provided a nutritional supplement to Resident #86 between 2:00 AM - 2:30 AM. LPN #1 stated at approximately 4:30 AM, they were alerted by CNA #1 that Resident #86 was unresponsive. LPN #1 stated that they responded the resident's room. Resident #86 was cyanotic, cold to the touch and had bubbling excretions from their mouth. LPN #1 stated Resident #86 had no detectable vital signs, and in their professional opinion there were no signs of revival or survival. Additionally, LPN #1 stated since they were unable to pronounce a resident deceased , they attempted to contact the DON, and notified the on-call physician. During a telephone interview on [DATE] at 8:57 AM, the DON stated they were on sick leave the date of the incident ([DATE]) and had a missed telephone call from the facility. The DON stated they could not recall what time they returned the call to the facility but was informed by LPN #1 that Resident #86 was found unresponsive and no further details were provided. Additionally, the DON stated if a Full Code resident was found unresponsive, CPR should be started immediately, especially in the presence of active bubbling. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 9:38 AM, Physician #1 stated they received an on-call notification from the facility on [DATE] between 6:00 AM and 7:00 AM to pronounce a resident deceased and there was no further information provided. Physician #1 stated there should be an attempt at resuscitation in all residents that are a Full Code status. During an interview on [DATE] at 10:55 AM, the Regional Administrator stated they expected staff to follow facility P&P regarding CPR. During an interview on [DATE] at 10:58 AM, the Administrator stated they were aware of the lack of RN coverage multiple dates, including [DATE]. Based on the survey team's observations, staff interviews and record review the survey team verified the facility removed the immediacy as of [DATE]. Corrective actions the facility took to remove the immediacy included: -Immediate staff education on Code Blue response to all active LPN and RN staff. -A reporting system was put into place for times when there was not a Registered Nurse on site. -Immediate education to all LPN and RN staff on the notification and reporting process. The reporting system included names and contact information. This is information was posted at the nurses' stations and by the facility time clock. 415.2 (e)(2)(iii)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 39086 Based on interview and record review conducted during the Standard survey completed on 3/11/22, the facility did not use the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week and the facility did not have a designated RN to serve as the Director of Nursing (DON) on a full-time basis. Specifically, reviewed for staffing revealed an RN was not scheduled for eight consecutive hours per day on multiple dates December 4, 2021 through March 6, 2022, and an RN was not designated as DON from 12/30/21 through 3/7/22. The findings are: Review of a facility policy and procedure (P&P) titled Contingency Staffing Plan dated 3/13/2020 documented; it is the facility's policy to ensure that in the event of a disaster or emergency that a contingency staffing plan is in place so that all residents can be provided the necessary care. In the event of a disaster, whether environmental or health- related, it is crucial to ensure that there are plans in place for contingency staffing in the event additional licensed and /or non-licensed personnel are needed. Review of a facility undated Job Description for DON provided by the Administrator documented; the DON assumes authority, responsibility and accountability for the delivery of nursing services in the facility. In collaboration with facility Administration, allocates department resources in an efficient and economic manner to enable each resident to attain and / or maintain the highest practical physical, mental and psychosocial well-being. Collaborates with other departments, medical professionals, consultants and organizations, including government agencies and advocacy groups, to develop, support and coordinate resident care, related administrative functions and to represent the interests of the facility. Essential Job Functions included; oversees nursing schedules to assure they meet resident needs/ as well as, regulatory and budgetary standards. Review of a facility report, untitled, identified as the facility census report by the Administrator dated 12/1/21 through 3/7/21 revealed the census was between 29 to 40 residents daily. Review of an untitled form, identified as the facility daily shift staffing sheets by the Administrator dated 12/1/21 through 3/6/22 revealed there was no documented evidence that a Registered Nurse (RN) was scheduled for eight consecutive hours on the following dates: December 4, 11, 19, 25, 26, and 30 2021; January 1, 8, 9, 10, 15, 16, 18, 22, 23, 29, and 30 2022; February 1, 2, 3, 4, 5, 6, 9, 10, 12, 13, 19, 20, 26, and 27 2022 and March 3 and 6 2022. Review of the facility Daily Nurse Staffing Forms from 12/1/21 through 3/6/22 revealed there was no documented evidence that an RN was scheduled for eight consecutive hours on the identified dates. Review of facility daily reports titled; Punched In and Out; dated 12/1/21 through 3/6/21 revealed there was no documented evidence that an RN was scheduled for eight consecutive hours on the identified dates. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a titled report, Time Cards, dated 12/1/21 through 3/6/22 for the DON, Regional RN Interim DON #1, Regional Director Quality Assurance, and Regional RN #2, revealed there was no documented evidence that an RN was scheduled for eight consecutive hours on the identified dates. Review of a handwritten sign hanging on the nurses station documented; Nurses: The sister facility will be available to take any calls from this facility that require an RN, between 7 PM to 7 AM. They can assist over the home to provide guidance. Day issues can be addressed with RN in the building. From the hours of no RN please call Administrator starting 2/11/22. During an interview on 3/7/22 at 10:41 AM the Administrator stated the DON has not been here for a while related to medical issues, there has not been an RN appointed to be the interim DON and the New York State Department of Health has not been informed of the lack of full time DON coverage. The Administrator stated the facility corporate nurses have been assisting with RN tasks. The Administrator appointed RN Interim DON #2 at this time during the interview. During an interview on 3/7/22 at 11:07 AM RN Interim DON #2 stated they started working for the facility on 2/17/22 as an agency nurse and was appointed as the interim DON this morning during the entrance conference interview. During another interview on 3/9/22 at 6:33 AM RN Interim DON #2 stated prior to 3/7/22 they were aware there was a sign at the nurse's station to contact a sister facility that require an RN guidance between 7 PM - 7 AM dated 2/11/22. During an interview on 3/7/22 at 11:13 AM Regional RN /Interim DON #1 stated they were aware the DON was out on medical leave, they had worked covering some RN duties in the building and had not been appointed to be the interim DON during the DON's absence until today (3-7-22). During an interview on 3/7/22 at 11:18 AM the Regional Administrator stated they were aware the DON had been out on medical leave and Regional RNs have been covering some RN duties. The Regional Administrator stated there should be a full time DON and doesn't know who is covering the DON duties and referred the question to the Administrator. During an interview on 3/8/22 at 12:06 PM the Administrator stated the DON's last day worked was 12/29/21 related to medical issues. During a phone interview on 3/9/22 at 8:57 AM the DON stated the facility's corporation was aware they had been out on medical and unable to work. The DON stated Regional RN Interim DON #1 and Regional Administrator were aware and believes corporate provided some RN coverage for specific RN duties and does not know who is covering DON duties or making DON decisions. The DON stated the facility should have appointed a full time RN to be the acting interim DON while they were out sick. In addition, the DON stated there should be an RN in the facility at least eight consecutive hours ever 24-hour period and was not aware the facility was not meeting this requirement. The DON stated the Scheduling Coordinator is responsible for scheduling and the Daily Nurse Staffing Form should be accurate at all times. During an interview on 3/10/22 at 8:25 AM LPN #2 stated they were aware there is a regulation the facility is to schedule an RN for eight consecutive hours every 24-hour period and the facility has not met that requirement especially on weekends. LPN #2 stated since the DON has been out on medical leave the frequency of a lack of RN coverage has increased. LPN #2 state they had not been informed or educated on a change in DON status until yesterday (3-9-22). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335595	A. Building B. Wing	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dunkirk Rehabilitation & Nursing Center	447 449 Lake Shore Drive West Dunkirk, NY 14048

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

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/10/22 at 9:56 AM LPN #5 stated they are aware the facility should have an RN at least 8 hours / 24 hours coverage and stated there is a lack of RN coverage on multiple days especially on the weekends. LPN #5 stated they had not been informed or educated on a change in DON status until yesterday (3-9-22). During a second interview on 3/10/22 at 4:00 PM Regional RN / Interim DON #1 stated they had not returned to work until mid-February 2022 and started working at this facility to cover some RN hours and realized the facility did not have an RN scheduled daily for eight hours as required. Regional RN / Interim DON #1 stated they had hired Agency RN / Interim DON #2 as a full time RN, but there continued to be a lack of RN 8-hour coverage in the building and the Administrator was aware. During an interview on 3/11/22 at 9:43 AM Human Resources Director / Scheduling Coordinator stated they had been in charge of scheduling since November 2021 and is aware there should be an RN scheduled for eight hours / 24 hours per requirement. They stated they were unable to schedule an RN daily and aware there was not eight hours of RN coverage as required for all the dates indicated. The Human Resource Director / Scheduling Coordinator stated the Administrator, and the Regional Director of Quality Assurance (QA) was aware, and they were not provided any further direction how to staff the facility with an RN. During an interview on 3/11/22 at 10:53 AM the Administrator stated they anticipated the DON to return and did not appoint or delegate an RN as an interim DON and did not delegate all the DON's job tasks to other RNs. The Administrator stated the Ownership and Corporate Administrator was aware the DON was not in the building and out on medical leave since 12/29/21 and was not directed to appoint an interim DON. The Administrator stated there was no direction provided to the nursing staff of who to call in the DON's absence until a note was posted at the nurse's station on 2/11/22 for the nurses to call the sister facility for assistance if an RN is required on the off shifts. In addition, the Administrator stated they were aware the facility did not have an RN scheduled for eight consecutive hours per 24 hours as required on multiple dates. The Administrator reviewed the dates identified and agreed the information was correct. The Administrator stated they should have notified Corporate and Ownership that the facility was unable to schedule an RN as required. During a phone interview on 3/11/22 at 11:59 AM the Chief Operating Officer (COO) stated they were not aware the facility was unable to schedule an RN eight consecutive hours per 24 hours as required. The COO stated they should have been notified and would have offered bonuses and provided additional assistance if they were aware. During an interview on 3/11/22 at 12:18 PM the Corporate Administrator stated they were not aware the facility was unable to schedule an RN eight consecutive hours per 24 hours as required and would have expected the Administrator to have notified Corporate. 415.13(b)(1)

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Dunkirk Rehabilitation & Nursing Center	447 449 Lake Shore Drive West Dunkirk, NY 14048

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39086 Based on interview and record review conducted during an Extended Standard survey started on [DATE] and completed on [DATE], the facility was not administered in a manner that enabled 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, the Administrator did not ensure a Registered Nurse (RN) was scheduled eight consecutive hours per 24-hour period as required and did not designate a full time Director of Nursing (DON) when the DON was off for an extended period. In addition, the Administrator did not ensure there was an effective system in place when there was no RN coverage in the building to respond to an emergency in accordance with facility policy and protocols. The findings are: Refer to: F 678 - Cardio-Pulmonary Resuscitation (CPR) - scope/severity (S/S)= J F 727 - RN 8 hours/ 7 days/ Week, Full Time DON - S/S = F Review of an undated Administrator Job Description provided by the facility documented position purpose was to supervise all clinical and administrative functions within the nursing facility. Essential functions included: develop and implements facility management systems, and ensures compliance with all Federal, State and company policies and regulations. Personnel Functions documented to oversees all department's schedules to assure they meet resident needs and monitors regulatory standards; participates in the recruitment and selection of all department personnel and assures sufficient staff are hired; and assures staff is trained in emergency procedures. a.) Concerns rising to the level of immediate risk to resident health and safety/Substandard Quality of Care (SQC) included the provider's failure to provide basic life support, including CPR to an unresponsive resident who had full code status. This was an isolated incident that resulted in actual harm with the likelihood to affect all residents with a full code status. On [DATE] Licensed Practical Nurse (LPN) #1 was notified by Certified Nurse Aide (CNA) #1 at approximately 4:30 AM that Resident #86 was unresponsive. LPN #1 observed Resident #86, who was unresponsive without a pulse, respirations, or blood pressure and had bubbling excretions from their mouth. LPN #1 failed to initiate a Code Blue (emergency response) to summon additional help, failed to activate the 911 (EMS) system, and failed to provide CPR efforts for a resident who was a full code. LPN #1 instead contacted the Director of Nursing (DON) by telephone, without response. LPN #1 stated during interview it was their professional judgment to not perform CPR. LPN #1 did not provide documented clear evidence to support clinical signs for The American Heart Association (AHA) guidelines of irreversible death at the time the resident was observed unresponsive. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 10:53 AM, the Administrator stated the DON had been out on leave since [DATE] and they did not designate an RN to act as a full -time interim DON. The Administrator stated there was no direction provided to the nursing staff of who to call in the DON's absence until a note was posted at the nurse's station on [DATE]. In addition, the Administrator stated they were aware the facility did not have an RN scheduled for eight consecutive hours per 24 hours as required. During an interview on [DATE] at 11:00 AM, the Administrator stated they would have expected the LPN to have initiated CPR and follow the Code Blue policy and initiate 911. The Administrator stated LPNs cannot assess and determine the time of death of a resident because it is not within their scope of practice and should have contacted an RN. b.) The facility did not use the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week and the facility did not have a designated RN to serve as the Director of Nursing (DON) on a full-time basis. Review of facility daily reports titled Punched In and Out dated [DATE] through [DATE] revealed there was no documented evidence that an RN was scheduled for eight consecutive hours on the following dates: [DATE], 19, 25, 26, and 30 2021; [DATE], 9, 10, 15, 16, 18, 22, 23, 29, and 30 2022; February 1, 2, 3, 4, 5, 6, 9, 10, 12, 13, 19, 20, 26, and 27 2022 and [DATE] and 6 2022. During an interview on [DATE] at 10:53 AM, the Administrator stated they did not designate an RN as an interim DON to cover while the DON was out on leave, and did not delegate all the DON's job tasks to other RNs. The Administrator stated the Ownership and Corporate Administrator was aware the DON was out on leave since [DATE] and was not directed by them to appoint an interim DON. The Administrator also stated they were aware the facility did not have an RN scheduled for eight consecutive hours per 24 hours as required and should have notified Corporate/Ownership that the facility was unable to schedule an RN as required. During a telephone interview on [DATE] at 11:59 AM, the Chief Operating Officer (COO) stated they were not aware the facility was unable to schedule an RN for eight consecutive hours per 24 hours as required. The COO stated they should have been notified and would have offered bonuses and provided additional assistance if they were aware. During an interview on [DATE] at 12:18 PM, the Corporate Administrator stated they were not aware the facility was unable to schedule an RN eight consecutive hours per 24 hours as required and would have expected the Administrator to have notified Corporate. 415.26