STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335595	A. BUILDING _____ B. WING _____	06/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during a Focus Infection Control Survey (Complaint #NY 306) completed on 6/10/20 the facility did not maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise for two (Residents #1 and #4) of four residents reviewed. Specifically, residents (Residents #1 and #4) were not assessed by a Registered Dietician (RD) and there were no nutritional interventions initiated for significant weight loss. The findings are: The facility policy regarding titled Weights dated 9/2017 documented the facility will ensure all residents maintain to the extent possible acceptable parameters of nutritional status. The dietician/designee will conduct a calorie count if appropriate, evaluate the food intake and assess the need for evaluation; collaborate with nursing and other disciplines to plan and implement a plan of care; request orders from physician based upon assessment and recommend to the physician appropriate methods of assisting the resident to attain optimum nutritional status; and address nutritional status and interventions in resident's plan of care. 1. Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS, a resident assessment tool) dated 3/5/20 documented the resident had severe cognitive impairment. Review of the Comprehensive Care Plan initiated 3/9/20 documented Resident #4 had a nutritional problem or was at risk for nutritional problems related to dementia, gastro-[MEDICAL CONDITION] reflux disease (GERD), limited physical mobility, impaired skin integrity and weight loss. Interventions include, RD to evaluate and make diet changes and recommendations as needed. Review of the Initial Nutritional Comprehensive Assessment completed by the Diet Technician (DT) dated 3/9/20 documented the resident was 72 inches tall with the most recent weight 198.8 pounds, usual body weight at 198 pounds and Ideal Body Weight (IBW) at 178 pounds. The assessment also documented, Resident #4 was admitted with a Stage II pressure injury present on the coccyx. The average meal intake documented at 50-100% (percent). Review of the Monthly Weight Report documented weights as followed: February = 198.8 pounds (lbs) March = 195.6 pounds April = 185.6 pounds May = 171.6 pounds (Weight loss of 13.6% in three months) June = 168.5 pounds (Weight loss of 15% in four months) Review of the Nutritional Progress Notes and Nutritional Assessments from 2/6/20 until 6/10/20 revealed there were no further nutritional assessments or documented evidence that the resident was assessed and monitored by the DT or an RD regarding the resident's weight loss and nutritional status. Review of a physician note dated 5/22/20 documented resident #4's weight was at 171.6 pounds, weight prior 185.6 pounds, Ideal Body Weight 178 pounds. Appears to be stable in weight. During an interview on 6/9/20 at 11:30 AM, Diet Technician (DT) #1 stated she was covering the residents' nutritional care for two facilities and was also the Food Service Director at one of those facilities. She said, Resident #4 was on her radar to look at due to their weight loss but she had not completed any further assessments. During an interview on 6/9/20 at 2:30 PM, the Director of Nursing (DON) stated there has not been a RD on staff since February 2020, but the Diet Technician was covering the nutritional aspect for the facility. During an interview on 6/9/20 at 11:15 AM, the Administrator stated the RD that was working there left sometime earlier this year. He was aware that a RD was required to work at the facility. 2. Resident #1 had [DIAGNOSES REDACTED]. Resident #1 receives [MEDICAL TREATMENT] every Monday, Wednesday and Friday. The MDS dated [DATE] documented the resident had moderate cognitive impairments. Review of the Nutritional Comprehensive Assessment completed by DT #1 dated 2/27/20 revealed Resident #1 was admitted to the facility after a fall. The resident's most recent weight on 2/18/20 was 110 lbs. The resident's food intake was fair to poor with refusals noted. Review of the CCP initiated on 3/2/20 and revised on 6/8/20 revealed the resident #1 was at nutritional risk related to [MEDICAL CONDITION], DM, adult failure to thrive, refusals of meals and medications. The goal was to maintain weight within 3 pounds of [MEDICAL TREATMENT] recommendations, no signs/symptoms of malnutrition, and consuming at least 50% of at least two meals daily. Interventions included that the Registered Dietician was to evaluate and make diet change recommendations as needed. Review of the Monthly Weight Report documented weights as followed: February = 110.0 pounds March = 107.2 pounds April = 91.4 pounds (Weight loss of 16.9% in two months) May = 84.8 pounds (Weight loss of 22.9% in three months) June = 85.1 pounds (Weight loss of 22.6% in four months) Review of the Nutritional Progress Notes and Nutritional Assessments from 2/27/20 until 6/10/20 revealed there were no further nutritional assessments or documented evidence that the Resident #1 was assessed and monitored by the DT or an RD regarding the resident's weight loss and nutritional status. Additionally, there was no documented evidence of weight recommendations made by the [MEDICAL TREATMENT] staff. Review of a physician note dated 4/20/20 documented the patient lost over 20 lbs in the past 8 weeks, since the time of their admission to the facility. The note documented abnormal weight loss due to not liking food and GI (gastro-intestinal) side effects of Calcium Acetate (supplement). Review of meal intake sheets from 5/1/20 - 6/10/20 for breakfast, lunch and dinner revealed the resident often refused the meals. Many times, the intake was documented as 0-25% or 25-50%. Resident #1 had occasional times when 50-75% or 75-100% was consumed. During an interview on 6/9/20 at 11:30 AM, Diet Technician #1 stated she was aware of Resident #1's weight loss. The resident was refusing to eat. The family had been bringing in food but now there was no visitation allowed. During an observation on 6/9/20 at 12:00 PM the Resident #1 appeared thin and frail. During an interview on 6/9/20 at 3:00 PM, the Director of Nursing (DON) stated the resident had not been evaluated by a Registered Dietician since admission to the facility. The facility had not had a registered dietician on staff at the facility since February 2020. The initial nutritional assessment on 2/27/20 was completed by the diet technician. The DON stated Resident #1 should have been evaluated by an RD and was not because the facility did not have one. 415.12 (i)(1)
F 0801 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.** Based on interview and record review conducted during an Infection Control Focus Survey (Complaint #NY 306) completed on 6/10/20 the facility did not ensure that a qualified dietician was employed either full time, part time, or on a consultant basis. Specifically, the facility has not employed a Registered Dietician (RD) since February 2020 and the Dietary Technician (DT) did not receive frequent scheduled consultations from a Registered Dietitian (RD). The finding is: The facility policy regarding titled Weights dated 9/2017 documented the facility will ensure all residents maintain to the extent possible acceptable parameters of nutritional status. The dietician/designee will conduct a calorie count if appropriate, evaluate the food intake and assess the need for evaluation; collaborate with nursing and other disciplines to plan and implement a plan of care; request orders from physician based upon assessment and recommend to the physician appropriate methods of assisting the resident to attain optimum nutritional status; and address nutritional status and interventions in resident's plan of care. During an interview on 6/9/20 at 11:30 AM, DT #1 stated she covered the nutritional care of residents for two different facilities and was the Food Service Director at one of those facilities.

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

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.

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F 0801 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) The DT stated there was no RD on staff at the facility and she was doing what she could to cover the nutritional aspects in both facilities. During an interview on 6/9/20 at 2:30 PM, the Director of Nursing (DON) stated there has not been a RD on staff since February 2020. The Diet Technician was covering the nutritional status of the facility. During an interview on 6/9/20 at 2:45 PM, the Administrator stated there has not been a RD on staff since February 2020. The Diet Technician has been covering the nutritional status of the facility. He stated he was aware of the need for an RD. 415.14(a)(1),(2)