

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335184	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/14/2025
NAME OF PROVIDER OR SUPPLIER  Van Duyn Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  5075 West Seneca Turnpike Syracuse, NY 13215	
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on record review and interviews during the abbreviated survey (NY00361295), the facility did not ensure they provided or obtained routine and emergency medications and biologicals in order to meet the needs of each resident for 2 of 3 residents reviewed (Residents #2 and 4). Specifically: Resident #2 had physician orders for Lithium (psychotropic medication for mood stabilization), the Lithium was not obtained timely and as a consequence, the resident had a low Lithium blood level. Resident #4 was a newly admitted and had physician orders for Sevelmer and cinacalcet ( for kidney disease) and the medications were not obtained timely (11 days). Findings include: The 9/2018 facility policy, "Ordering and Receiving Non-Controlled Medications," documented medications and related products were received from the pharmacy on a timely basis. Medications were reordered based on estimated refill date and the pharmacy prescription label, or at least 3 days in advance to ensure adequate supply was on hand. The refill order was called in, faxed, sent electronically, or otherwise transmitted to the pharmacy.</p> <p>1) Resident #3 had diagnoses including schizophrenia. The 10/24/24 Minimum Data Set assessment documented the resident's cognition was intact, they required supervision/touch assistance with rolling left and right and partial/moderate assistance with chair/bed-to-chair transfers and they were receiving an antipsychotic medication.</p> <p>The 10/18/2024 physician order documented Lithium Carbonate (psychotropic medication for mood stabilization) 150 milligrams, 3 tablets twice daily</p> <p>The 10/18/2024 Comprehensive Care Plan documented the resident had a Level 2 Mental Health Evaluation and they used psychotropic medications. Interventions included observe for changes in mood or behavior (withdrawal, restlessness, irritability), monitor side effects, and administer medications as ordered.</p> <p>The November 2024 Medication Administration Record documented Lithium was not administered:</p> <p>-on 11/18/2024 at 5 PM, 11/19/2024 at 8 AM and 11/19/2024 at 8 AM by Licensed Practical Nurse #7.</p> <p>-on 11/20/2024 at 5 PM by Licensed Practical Nurse #8.</p> <p>The 11/18/2024 untimed nursing note by Registered Nurse #8 documented they received a call from the family with concerns the resident was experiencing Lithium toxicity (excess Lithium in the body leading to symptoms). The resident was noted with slight shakiness in their hands and denied other symptoms. The medical provider was notified with orders to obtain a Lithium level (blood test).</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 335184
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 11/19/2024 untimed nursing note by Registered Nurse #8 documented a Lithium level was drawn that day.</p> <p>The 11/20/2024 laboratory report documented the resident's Lithium level was low at 0.3 mmol/L (millimoles per liter, normal range 0.6-1.2 millimoles per liter).</p> <p>The 11/21/2024 medical provider note documented the resident's family member believed the resident was suffering from Lithium toxicity and discussed with them the resident's Lithium level was low. The family member got upset and stated the resident was not acting themselves and was constantly shaking and lethargic. The resident did not appear to be shaking or lethargic at this time. The resident was transported to the hospital per family's request.</p> <p>During an interview on 6/26/2025 at 8:31 AM, Licensed Practical Nurse #7 stated the purpose of the Medication Administration Record was to direct them on which medication was due and to document that it was given. When a medication was not given they were required to document that it was not given on the Medication Administration Record. When they documented "not administered" that meant the medication might have been not available or the resident refused the medication. They did not recall the reason they did not administer the resident's Lithium on 11/18 and 11/19/2025. Lithium was not available in their automated medication dispensing machine.</p> <p>On 6/26/2025 at 9:15 AM, Licensed Practical Nurse #8 was not able to reached for an interview.</p> <p>During an interview on 7/8/2025 at 10:25 AM, Pharmacist #11 stated they were in charge of Quality Assurance for the facility's pharmacy. On 10/19/2024, the pharmacy delivered 150 tablets of Lithium and sent another 30 tablets on 10/26/2024 for Resident #3. The 180 tablets should have lasted one month and would have run out on or around 11/17/2024. They saw in their system a request to refill Lithium on 11/18, 11/19 and 11/20/2024, however the computer system considered it too soon to refill the Lithium and rejected the refill. That was a pharmacy computer error. No staff from the facility called the pharmacy to inquire about the medication. Had the facility called, the pharmacy would have investigated the issue and found their error and would have been able to send the medication. Missing several doses of Lithium over the course of a few days would cause a low blood Lithium level.</p> <p>During a telephone interview on 7/14/2025 at 9:34 AM, Registered Nurse Manager #21 stated the licensed practical nurses could send the pharmacy a request to refill medications. If the medications did not arrive with the next pharmacy delivery, they expected the nurse to call the pharmacy to inquire about the medication. If a medication was refilled too soon, they could get permission for a certain amount of medications to be sent or get an emergency supply. The medical provider should be notified for further instruction as well. They did not recall if staff notified them of the resident missing medications from 11/18-11/21/2024, although they should have notified them if not. The resident did not get their Lithium timely.</p> <p>2) Resident #4 had diagnoses including End Stage Renal Disease, Diabetes and malnutrition. The 6/11/2025 Minimum Data Set assessment documented the resident's cognition was intact and they were receiving dialysis (procedure to remove waste products/excess fluid from kidneys when they are no longer able to do so adequately).</p> <p>The 6/5/2025 physician orders documented:</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- dialysis on Monday, Wednesdays and Fridays;</p> <p>- cinacalcet (lowers blood calcium levels related to dialysis treatments) 60 milligram tablet daily for End Stage Renal Disease; and</p> <p>- Sevelamer Carbonate (lowers blood phosphorus levels for those with chronic kidney disease receiving dialysis) 800 milligram tablet, 2 tablets at 7 AM, 12 PM and 5 PM.</p> <p>The 6/5/2025 Comprehensive Care Plan documented the resident had End Stage Renal Disease and was receiving dialysis. Interventions included to receive dialysis treatments as scheduled and medicate per physician orders.</p> <p>The June 2025 Medication Administration Record documented cinacalcet 60 milligrams daily was not administered:</p> <ul style="list-style-type: none"> <li>- by Licensed Practical Nurse #10 on 6/6, 6/9-6/12, and 6/14-6/16/2025;</li> <li>- by Licensed Practical Nurse #12 on 6/7/2025;</li> <li>- by Licensed Practical Nurse #7 on 6/8/2025; and</li> <li>- by Licensed Practical Nurses #13 on 6/13/2025.</li> </ul> <p>The June 2025 Medication Administration Record documented Sevelamer 800 milligrams, 2 tabs three times daily was not administered:</p> <ul style="list-style-type: none"> <li>- by Licensed Practical Nurse #10 on 6/6-6/12, 6/15-6/16, 6/18 and 6/2025 x 2 doses;</li> <li>- by Licensed Practical Nurse #14 on 6/6/2025 X 1 dose;</li> <li>- by Licensed Practical Nurse #15 on 6/6/2025 x 1 dose;</li> <li>- by Licensed Practical Nurse #12 on 6/7/2025 x 2 doses;</li> <li>- by Licensed Practical Nurse #20 on 6/7 and 6/10/2025 x 1 dose;</li> <li>- by Licensed Practical Nurse #7 on 6/8/2025 x 2 doses;</li> <li>- by Registered Nurse #17 on 6/8, 6/9, 6/12, 6/13 and 6/16/2025 x 1 dose;</li> <li>- by Licensed Practical Nurse #18 on 6/11/2025 x 1 dose;</li> <li>- by Licensed Practical Nurse #13 on 6/11/2025 x 1 dose; and</li> <li>- by Licensed Practical Nurse #19 on 6/14 and 6/15/2025 x 1 dose.</li> </ul> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 7/10/2025 at 10:08 AM, Pharmacist #11 stated the first time cinacalcet and Sevelamer were filled for Resident #4 was on 6/17/2025. Sevelamer was in the facility's automated medication dispensing machine, however cinacalcet was not. Pharmacist #11 checked the facility records for their automated medication dispensing machine and there was no record that Sevelamer was removed from the machine. Implications for not getting these medications timely could result in symptoms the medications were used to prevent and could potentially worsen kidney disease as a result from not getting them.</p> <p>During a telephone interview on 7/11/2025 at 8:23 AM, Licensed Practical Nurse #19 stated the resident's medications were not available to administer on 6/14 and 6/15/2025. Those medications were supposed to be provided by dialysis and were not available in the automated medication dispensing machine. They notified the supervisor they did not have the medications.</p> <p>During a telephone interview on 7/11/2025 at 8:48 AM, Licensed Practical Nurse #16 stated if a medication was not available on their medication cart, they were supposed to order it and notify the supervisor. They could also check the automated medication dispensing machine. They did not recall what the issue was on 6/7 and 6/10/2025 or why the medications were not administered.</p> <p>During a telephone interview on 7/11/2025 at 9:07 AM, Licensed Practical Nurse #10 stated when a medication was not available, they usually ordered the medication and let the unit manager know. They had an automated medication dispensing machine at the facility that had some stock medications available for use. The physician should be notified if a medication was not available. On 6/6, 6/9, 6/10, 6/11, 6/12, and 6/14-6/16/2025, they did not administer Sevelamer or cinacalcet as they were not available. They let their unit manager know they did not have the medications. Those medications were typically provided to the facility by dialysis. They called dialysis at one point to inquire to where the medications were, and staff at the dialysis center told them their pharmacy did not take the resident's insurance and the facility needed to get the medications from the facility's pharmacy. Licensed Practical Nurse #10 called their pharmacy and they sent the medications. They stated with other residents, sometimes it could take up to 3 days to get the medications from dialysis. Licensed Practical Nurse #10 stated the resident did not get their medications timely.</p> <p>During a telephone interview on 7/14/2025 at 10:07 AM, Registered Nurse Manager #6 stated when physician orders were entered into the electronic record, they went directly to the pharmacy to be filled. If medications were not available on the medication cart, nursing staff should notify the manager, the medical provider, and the pharmacy. They believed they were aware the resident had no cinacalcet and Sevelamer between 6/6 and 6/16/2025. They called the dialysis center and spoke with staff there who reported the medication would be delivered. When the medication was not delivered, the dialysis center said it was due to an issue with the resident's insurance. At that point, they reached out to the facility's pharmacy and got the medication filled. The resident did not receive their medications timely.</p> <p>NYCRR 415.18(a)</p>		