

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 12/15/2025
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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observations, record review, and interviews conducted during the survey, the facility failed to ensure residents were treated with respect and dignity in a manner and in an environment that promotes maintenance or enhancement of quality of life, recognizing each resident's individuality for seven (7) of seven (7) anonymous residents reviewed. Specifically, seven (7) anonymous residents stated staff use foul language, ethnic slurs and laugh at other residents in the hallways and around residents, making them feel uncomfortable. Findings include: The facility policy Dignity and Respect last revised 05/2025, documented residents had the right to be valued as an individual, to be treated with consideration, dignity and respect in full recognition of their self-worth. Residents were to be treated in a manner that enhanced their quality of life, free from humiliation, harassment or threats. Staff were to ensure residents were treated as individuals, provided residents with safe, clean and comfortable surroundings. The undated facility policy Code of Conduct documented that all affected individuals were treated with dignity and respect at all times. Any type of harassment, which included, offensive language or jokes, racial, ethnic, or religious slurs, were prohibited. Residents were to be treated with consideration, curtesy, respect and were sensitive to resident's background, culture, religion and heritage. During an observation on 12/03/2025 at 10:54 AM, Certified Nurse Aide #6 loudly said an ethnic slur in the hallway with staff and three (3) residents present. Multiple resident room doors were open. During an observation on 12/08/2025 at 3:17 PM, Certified Nurse Aide #7 laughed at an unidentified resident while they were confused and screaming in the dining area. Certified Nurse Aide #7 stated enthusiastically that the resident was difficult and laughed while 18 unidentified residents were in dining area. During an interview on 12/03/2025 at 12:41 PM, Resident #12 stated they have heard staff talk about residents in the hallway. They further stated foul language and ethnic slurs were used often by staff and felt that was disgusting and awful. During a group interview on 12/04/2025 at 10:28 AM, seven (7) anonymous residents stated staff cussed and yelled at each other constantly. They stated racial slurs were used all day long by staff, who also made jokes about drug use. During an interview on 12/08/2025 at 3:09 PM, Certified Nurse Aide #6 stated they have heard staff use foul language and ethnic slurs in the hallway. They stated ethnic slurs and cussing should not be said, and that they did not recall having said an ethnic slur in the facility. During an interview on 12/08/2025 at 3:32 PM, Certified Nurse Aide #7 stated they never heard staff members laugh or talk about residents in the hallway. They had a resident that was confused and yelling out but did not believe they laughed or talked about them in the dining area. During an interview on 12/09/2025 at 8:41 AM, Licensed Practical Nurse #6 stated they never heard staff laughing or joking about a resident, at least not recently. Swearing in the hallway or laughing at a resident was not right. It was a dignity issue if staff laughed or made fun of a resident. During an interview on 12/09/2025 at 9:00 AM, Registered Nurse #4 stated they had heard staff swear in the hallway but had not heard staff use ethnic slurs. They further stated that staff should never say ethnic slurs, however, ethnic slurs were part of Black culture and used often. Registered Nurse #4 stated staff forgot not to use ethnic slurs. They stated the facility was the residents' home, and ethnic slurs and swearing made residents uncomfortable. They had not heard staff laugh or talk about a resident in the hallway. They further stated laughing and speaking about residents in the hallway made residents uncomfortable, humiliated and belittled; it was not dignified. During an interview on 12/12/2025 at 11:28 AM, Administrator #1 stated human resources recently provided re-education related to code of conduct and appropriate behavior on the floor. They stated that having heard staff used foul language and racial slurs was disappointing and disheartening. 10 New York Code Rules and Regulation 415.5(a)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews conducted during the survey, the facility failed to provide effective housekeeping and maintenance services on five (5) of five (5) resident units. Specifically, the facility did not ensure that resident rooms and common areas were clean and in good repair. Findings include: During observations on 12/03/2025 from 10:11 AM through 3:00 PM, on 12/04/2025 from 8:31 AM through 9:16 AM, on 12/05/2025 from 8:33 AM through 1:30 PM, on 12/08/2025 from 9:41 AM to 10:34 AM, and on 12/10/2025 at 10:53 AM: Strong urine odors were detected in rooms #555, #566 (two (2) observations), and #671 and in the north elevator lobby area. The toilets in rooms #572, #558, #655, and #671 were soiled with black or brown stain marks in the bowl. The soap dispenser located within the bathroom of room [ROOM NUMBER] was broken, and no soap was available. The paper towel dispenser was empty in rooms #565 and #568. The bedding had brown stains in room [ROOM NUMBER] (two (2) observations). The bedside table was stained with beverage cup marks or a dried brown substance in rooms #558 and #679. The fifth-floor unit A and B shower rooms had toilet paper stuck to the floor, a hairbrush and used washcloth on the shower bed, and the toilet paper dispenser was empty. Soiled linens were on the floor in rooms #555 (two (2) observations), #566, #576, #571, #558, and the fifth-floor shower. Trash, dirt, sticky substances, used surgical gloves, and/or food was found on the floors in rooms #557 (three (3) observations), #558, #559 (two (2) observations), #566, #571 (two (2) observations), #576 (two (2) observations), #581 (three (3) observations), #655, #671, and #675. Floor tiles were broken in room [ROOM NUMBER]. A ceiling tile was missing in room [ROOM NUMBER] (two (2) observations). The thermostat in room [ROOM NUMBER] made a hissing sound (three (3) observations). During an interview on 12/03/2025 at 11:12 AM, Resident #456 stated that the bathrooms were not cleaned, and the shower rooms often had feces in them. During observations on 12/09/2025 from 11:31 AM through 1:03 PM: Windows were soiled with water stains on the seventh-floor unit, sixth floor unit, fifth floor unit, fourth floor unit, and third floor unit. Old tape was on the walls in room [ROOM NUMBER]. The 5C, 6A, 6B, 6C, and 6D nurse's station half-wall enclosures were chipped or cracked. The walls had scrape marks in the 5C nurse station. Window and/or privacy curtains were off the hooks in rooms #428, #454, and #455. The following doors had black marks, scrape marks, and/or drip marks: 7042, 7026, seventh floor central shower room, 313, 353, 4212, 474, and 571. Floors in corridors and resident rooms were soiled in corners, next to walls, and/or at the base of the door frame with dirt, grime, scuff marks, and/or were not swept in the seventh-floor unit ice machine area, third floor unit, fourth floor unit, fifth floor unit and sixth floor unit. Floors had scuff marks and/or were un-swept in room [ROOM NUMBER], fifth floor south corridor, in the corridor by room [ROOM NUMBER], on the sixth floor by elevator #4 & #5, and the corridor between rooms #557 and #558. Floor tiles were chipped in room [ROOM NUMBER], by the 6C nurse station (five (5) each), the corridor by room [ROOM NUMBER] and the corridor by room [ROOM NUMBER]. Brass door guards on the clean utility and soiled utility rooms were tarnished and soiled with drip marks on the third-floor unit, fourth floor unit, fifth floor unit, sixth floor unit and seventh floor unit. Handrails were soiled with grime on the fourth floor and third floor. During an interview on 12/09/2025 at 3:01 PM, Director of Environmental Services #1 stated that in the areas described, they would clean, properly hook curtains, and fill paper towel dispensers. Director of Environmental Services #1 stated that they would contact the maintenance department to have the exterior windows cleaned and to repair the floors and walls where necessary and contact the nursing department to help investigate the odors. During an interview on 12/12/2025 at 11:26 AM, Assistant Administrator #1 stated audits are still in progress, things are in place and are looked at by many staff members. They stated there was a push with housekeeping but there was a fine line between resident choice and preferences, building trust with residents, and identifying hazards that may disrupt their preferences. They stated this was also being addressed in a behavioral wellness committee. New York Codes, Rules, and Regulations Title 10 S415.5(h)(4)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure that residents received treatment and care in accordance with professional standards for one (1) (Resident #1) of one (1) resident reviewed. Specifically, Resident #1 was observed to have an old bandage on their left forearm with no documentation in the resident's medical records. Findings include: Resident #1 was admitted to the facility with diagnoses of Parkinson's disease (a progressive brain disorder affecting movement), dysphagia (difficulty swallowing food or liquids), and dementia (a group of symptoms affecting memory, thinking, and social abilities). The Minimum Data Set (a resident assessment tool) dated 10/10/2025 documented the resident was understood, could understand others and was cognitively intact. During an observation on 12/04/2025 at 9:54 AM, a bandage was noted on Resident #1's left forearm dated 12/01/2025. Resident #1 stated they did not know what was under the bandage but that it might be a skin tear. During an observation on 12/05/2025 at 11:47 AM, the bandage was noted to still be in place with the date of 12/01/2025. There was no documented evidence of orders for a treatment to the left arm. There was no documented evidence of entries on either the Medication Administration Record or Treatment Administration Record for December 2025 for a bandage or dressing change on the left forearm. There were no progress notes in November 2025 or December 2025 documenting the presence of any skin issue on the left forearm. There was no documented evidence of recent Incident and Accident forms that could have indicated the source of any skin issues on the left forearm. In a Nurses Note dated 12/05/2025, Registered Nurse #2 documented the bandage was removed and a dry, healed area was noted. During an interview on 12/05/2025 at 10:27 AM, Licensed Practical Nurse #1 stated they changed the bandages on 12/01/2025 and had not worked between then and 12/05/2025. They did not recall what was under the bandage, but thought it was a skin tear. They stated there had been a bandage on it prior, so they assumed the issue had been reported. They did not recall if there was an order to change the bandage and expressed surprise when the Treatment Administration Record was reviewed and there was no order. During an interview on 12/08/2025 at 9:15 AM, Registered Nurse #1 stated they would expect an order for any dressing that was on a resident. They stated that any injury should be accompanied by an Incident and Accident report. During an interview on 12/09/2025 at 10:40 AM, Registered Nurse #2 stated there was nothing under the bandage that was removed on 12/05/2025. They stated when a new skin issue is found, they are notified, and they were not notified for any new skin issues for Resident #1. They stated there should be orders for dressings and bandages. During an interview on 12/09/2025 at 10:53 AM, Director of Nursing #1 stated skin issues should be reported, and dressings required an order and entry onto the Treatment Administration Record. 10 New York Codes, Rules, and Regulations 415.12</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observations and interviews conducted during the survey, the facility failed to ensure residents were provided food and drink that was palatable, flavorful, and at an appetizing temperature for two (2) of two (2) meals reviewed (lunch meal on 12/08/2025 and breakfast meal 12/09/2025). Specifically, food was not served at palatable and appetizing temperatures during the lunch meal of 12/08/2025 and breakfast meal on 12/09/2025. Additionally, seven (7) anonymous residents during a resident council meeting and seven (7) residents (Resident's #4, 121, 175, 211, 238, 277, 493) separately interviewed stated the food did not taste good and was cold. Findings include: The 09/2025 revised facility policy Fine Dining Policy and Procedure documented the Certified Nursing Aides would serve the residents their food per meal ticket and would ensure the tray was accurate. The United States Department of Agriculture Food Safety and Inspection Service guide provided by the facility stated hot food would be held at 140 degrees Fahrenheit or warmer and cold food would be held at 40 degrees Fahrenheit or colder. During an interview on 12/03/2025 at 9:24 AM, Resident #277 stated they did not eat the food at the facility because it was overcooked and cold. During an interview on 12/03/2025 at 10:53 AM, Resident #121 stated the meat was tough to chew at times and was very dried out. The following lunch observations were made on 12/03/2025:- At 11:56 AM, Resident #121's tray ticket documented they were to receive one serving of tossed salad, six slices of orange wedges, and mushroom gravy. They did not receive these items during the meal.- At 12:10 PM, Resident #361 received a pureed bright green substance on their tray. Their tray ticket did not document this item (chocolate milk, ensure clear, pureed baked chicken, extra gravy, mashed potatoes, pineapple, and magic cup).- At 12:49 PM, Resident #238 stated their food was cold and did not taste good. During an interview on 12/03/2025 at 3:10 PM, Resident #4 stated the food was rarely hot, which would have helped the food quality. During a resident group meeting on 12/04/2025 at 10:06 AM, seven (7) anonymous residents stated the food was not cooked right, the meat was very dry and tough and was often cold by the time they received their tray, so they ate out or ordered takeout often. During an observation on 12/08/2025 at 12:56 PM, Resident #175's meal was tested, and a replacement meal was ordered. Food temperatures were measured as follows: milk was 46.7 degrees Fahrenheit, grape juice was 46 degrees Fahrenheit, herb baked chicken was 137 degrees Fahrenheit, baked beans were 156 degrees Fahrenheit, and mandarin oranges were 46.1 degrees Fahrenheit. During an interview on 12/09/2025 at 8:18 AM, Resident #211 stated they did not get the items that were on their tray ticket, and the food was always cold because they were served at the end of the line. During an observation on 12/09/2025 at 8:40 AM, Resident #493's meal was tested in the presence of Certified Nurse Aide #14, and a replacement meal was ordered. Food temperatures were measured as follows: milk 51.4 degrees Fahrenheit, orange juice 53.2 degrees Fahrenheit, coffee 115.3 degrees Fahrenheit, health shake 52.2 degrees Fahrenheit, oatmeal 147.6 degrees Fahrenheit, scrambled eggs 110.2 degrees Fahrenheit, oatmeal 147.6 degrees Fahrenheit, super pudding 62.2 degrees Fahrenheit. During an observation on 12/09/2025 at 9:20 AM, Resident #277's meal was tested in the presence of Dietary Technician #1, and a replacement meal was ordered. Food temperatures were measured as follows: pancakes were 93.7 degrees Fahrenheit, hardboiled egg 111.1 degrees Fahrenheit, milk 48 degrees Fahrenheit, orange juice 49.5 degrees Fahrenheit. The pancakes tasted cold and were difficult to chew, the milk tasted warm, and the egg tasted cold. During an interview on 12/10/2025 at 9:45 AM, Certified Nurse Aide #15 stated the residents often complained the food was not hot and they forwarded the food complaints to the dietary server. During an interview on 12/10/2025 at 10:22 AM, Licensed Practical Nurse #14 stated the residents did not like the food because it was too cold, and the residents did not always get the items on their tray tickets. They forwarded the complaints to the food service managers. During an interview on 12/10/2025 at 12:01 PM, Food Service Director #1 stated the hallway carts did not hold food temperatures as much as they should, and the doors were damaged. They stated this was a critical issue they needed to correct, and they were aware there were issues with food temperatures in the past. 10 New York Codes, Rules and Regulations 415.14(d)(1)(2)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observations and interviews conducted during the survey, the facility failed to provide a safe, functional, sanitary, and comfortable environment on three (3) of five (5) resident units. Specifically, strong urine odors were detected in several areas throughout the facility. Findings include: During observations on 12/03/2025 from 10:11 AM through 3:00 PM, on 12/04/2025 from 8:31 AM through 9:16 AM, on 12/05/2025 from 8:33 AM through 1:30 PM, on 12/08/2025 from 9:41 AM to 10:34 AM, and again on 12/10/2025 at 10:53 AM, strong urine odors were detected in rooms #555, 566 (two (2) observations), and 671 and in the north elevator lobby area on the third floor. During an interview on 12/09/2025 at 3:01 PM, Director of Environmental Services #1 stated that they would contact the nursing department to help investigate the odors. 10 New York Codes, Rules, and Regulations 483.90(i)</p>