STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Van Duyn Center for Rehabilitation and Nursing	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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during the survey the facility failed to ensure each resident received adequate supervision to prevent accidents for one (1) of three (3) residents (Resident #2) reviewed for accidents. Specifically, Resident #2 had an active physician order for a 1:1 supervision safety watch (for prior smoking violations and behavioral symptoms directed toward others) that was not implemented when the resident was readmitted from a hospital stay on 01/15/2025. Subsequently, on 01/17/2025 Resident #2 was found with a self-inflicted laceration to their neck and superficial vertical cuts to both wrists. This resulted in actual harm to Resident #2 that was not Immediate Jeopardy. Findings include:The facility policy 1:1 Supervision, revised 07/2023, documented when a staff member was assigned to provide 1:1 supervision, they would: -Stay within the required distance of the resident at all times unless relieved by another staff member.-Report to the charge nurse before breaks and at the end of their shift and wait to be relieved by another staff member. -Complete necessary documentation. - When the need for continued 1:1 supervision was no longer deemed necessary, a medical order to discontinue the order was to be obtained and the 24-hour report would be updated. Resident #2 had diagnoses including opioid dependence, anxiety disorder, depression, and diabetes. The 12/12/2024 Minimum Data Set (a resident assessment tool) documented the resident had intact cognition, had no behaviors or rejection of care, required partial/moderate assistance for sitting to standing and used a wheelchair. The Comprehensive Care Plan, reviewed 01/15/2025 (upon readmission), documented the resident had behaviors, potential for behaviors, verbal aggression, socially inappropriate behaviors, disruptive behaviors, confabulated stories, and multiple smoking violations. Interventions included: Two (2) staff for care, approach in calm, positive manner, reapproach as needed, delay care until resident is calm and approachable, 1:1 supervision for safety. The care plan was reviewed 10/08/2024 and 01/06/2025 and documented no changes needed. The 09/23/2024 Psychological Evaluation by Psychologist #16 documented the resident had a PHQ-9 (depression assessment) score of 11, which indicated moderate depression symptoms. The resident was actively grieving their medical changes in condition and the resident was not a danger to themselves or others. Follow up would be on an as needed basis. The 12/28/2024 untimed nursing progress note by Registered Nurse Supervisor #19 documented the resident had a room search completed for smoking paraphernalia and was re-educated on the facility's no smoking policy. The 12/28/2024 untimed nursing progress notes by Registered Nurse #7 documented the following: -Resident #2 was re-educated on smoking cessation and facility non-smoking policy. The Interdisciplinary Team met and agreed the resident was to be placed on a 1:1 supervision for safety. -At 6:25 PM, a telephone order was obtained from Nurse Practitioner #21 for a 1:1 safety watch. The 12/30/2024 at 12:17 PM Physician #20 order documented resident was on 1:1 for safety with a start date of 12/30/2024 and end date on-going. The 01/05/2025 and 01/07/2025 Certified Nurse Aide 4th floor assignment sheets did not document the resident was on a 1:1 safety watch. The (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	01/07/2025 at 1:43 PM nursing progress note by Registered Nurse #7 documented the 1:1 supervision for safety continued. The 01/07/2025 at 3:28 PM nursing progress note by Licensed Practical Nurse #8 documented the resident was out on an appointment and was sent to the hospital for admission via the physician's recommendation. On 01/15/2025 at 3:56 PM, Resident #2 was re-admitted to the 7th floor rehabilitation unit of the facility. The 01/15/2025 at 4:50 PM readmission nursing progress note by Registered Nurse #9 documented the resident was status post incision and drainage of the right thigh, orders were reviewed with Nurse Practitioner #4. Continue with 1:1 supervision as ordered. The 01/15/2025-01/17/2025 7th floor certified nurse aide assignment sheets did not document a 1:1 safety watch for Resident #2. There was no documented evidence the 12/30/2024 physician order the for 1:1 safety supervision watch was discontinued. The 01/17/2025 at 9:26 AM nursing progress note by Registered Nurse #12 documented Resident #2 was found on their bedroom floor with a large amount of blood under their head, both arms and hands. Upon assessment, the resident was observed with a laceration to their right neck and superficial vertical cuts to both wrists. Emergency services were contacted, and Resident #2 was transported to the hospital for evaluation. There were no documented 1:1 assignment sheets indicating the resident continued on 1:1 supervision from 01/15/2025 - 01/17/2025. During an interview on 09/10/2025 at 12:32 PM, Certified Nurse Aide #1 stated if a resident was on a 1:1 safety supervision watch, there would be a binder at the nurse's station for the certified nurse aides to document on. The binder would be kept in the resident's room and the certified nurse aide would hand it off to the next aide during shift change. The certified nurse aide assigned to the 1:1 safety supervision watch could not leave the resident until they were relieved by another staff member. During an interview on 09/16/2025 at 2:37 PM with Social Worker #11, they stated they recalled Resident #2 had gone out to the hospital and was readmitted on [DATE]. Social Worker #11 met with the resident to issue them a smoking violation on 01/17/2025 and stated they did not recall any staff with the resident for a 1:1 safety supervision watch. Resident #2 was alone in their room when they issued the violation. During an interview on 10/20/2025 at 1:05 PM, the Director of Nursing stated when a resident was readmitted from the hospital, they would be reassessed to determine if 1:1 supervision was still required, and they were not sure if this was specifically documented. Resident #1 was excited to return on 01/17/2025, was engaged, and seemed to be a different person upon return to the facility. The admission nurse (Registered Nurse #9) initially made the determination and then the next day, the unit manager (Registered Nurse #12) or another registered nurse reassessed. During an interview on 10/23/2025 at 2:19 PM, Nurse Practitioner #4 stated admission orders were placed by the admission nurse and reviewed either physically in the building or verbally over the phone with the provider. The provider did not have to be in the building, they would review the orders and approve them or discuss any changes. The 1:1 safety supervision watches were not ordered by the physician; they were determined by nursing but would be included in the orders for the physician to sign. They did not have access to Resident #2's records as they were no longer employed at the facility. During an interview on 10/24/2025 at 9:13 AM, Registered Nurse #9 stated they were the admission nurse who placed Resident #2's readmission orders in the electronic medical record. They stated 1:1 safety supervision watches were put into place by nursing and were dependent on the resident's behaviors on their unit. Resident #2 had a 1:1 safety supervision watch in place prior to the resident's hospitalization, and the order continued on readmission. If a resident was on a 1:1 safety supervision watch, staff were expected to be within reach of the resident at all times. There was typically no physician order for a 1:1 safety supervision watch, however, the medical providers reviewed all orders and signed off on them. During an interview on 10/25/2025 at 12:09 PM, Registered Nurse Unit Manager #16 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	stated Resident #2 was readmitted from the hospital on [DATE] and had a 1:1 safety supervision watch in place per the admission nurse's progress note. The admission nurse was responsible for assessing the resident and placing the orders into the computer, calling the medical provider and having them review the orders. Resident #2's 1:1 safety supervision watch was in effect per the admission nurse's progress note. A 1:1 safety supervision watch was assigned to the certified nurse aides by either the unit manager or medication nurse. The certified Nurse Aides documented every hour in a binder and were expected to stay within reach of the resident. If the resident went to the bathroom or dining room, staff watching them were expected to go with them. During an interview on 10/29/2025 at 10:50 AM, Certified Nurse Aide #17 stated they were familiar with Resident #2 and completed 1:1 safety watches for the resident prior to their hospitalization. Resident #2 was on a safety watch due to smoking. The resident resided on the 4th floor at that time. They stated the resident was independent, they thought the resident had a catheter and would transfer themselves to the toilet, and they would stand outside the door and knock frequently to check on them. Certified Nurse Aide #17 stated they were required to document on the resident's moods and what they were doing in a binder that was kept at the nurse's station. During an interview on 10/29/2025 at 12:58 PM, Certified Nurse Aide #18 stated they used to work on the 4th floor and recalled doing a 1:1 safety watch for Resident #2. They stated 1:1 watches were generally done if a resident was on a suicide watch, was caught smoking or were a danger to themselves or others. Resident #2 was on a watch for smoking. The 1:1 safety watches required the aide to stay within reach of the resident, including accompanying them to the bathroom but most aides just sat outside the door. They recalled sitting at the nursing station with Resident #2 and stated it was harder to do a 1:1 with Resident #2 because the resident was independent and mobile in a wheelchair. During a telephone interview on 12/12/2025 at 9:36 AM, Certified Nurse Aide #22 stated they recalled doing a 1:1 safety watch for Resident #2 on the 4th floor. They stated the resident was on a watch for smoking. 1:1 safety watches were assigned by either the staff scheduler or the nursing supervisor. During a 1:1 safety watch, Certified Nurse Aide #22 stated the required distance depended on the resident. There was no clear definition. Some residents required to be close to them while others just required to be within eyesight. Resident #2 used a wheelchair, had one leg but cared for themselves and only required to have them in eyesight to ensure they were not smoking. They went downstairs by themself for haircuts and shaves. They were not aware of any down or depressed moods and did not see the resident with any razors. During a telephone interview on 12/12/2025 at 12:20 PM, Certified Nurse Aide #23 stated they were familiar with Resident #2 and cared for them on the 4th floor and the 7th floor. Resident #2 had a 1:1 safety watch while on the 4th floor due to smoking. Required distance meant to stay close by the resident and they sat by the door. Resident #2 kept the bathroom door open and required minimal help with toileting unless they felt weak. They stated when the resident returned from the hospital, they cared for the resident on the 7th floor and the resident was not on a 1:1 safety watch. They stated the resident had belongings still in bags, there were no razors observed, and the resident did not state they felt like harming themselves. During a follow-up telephone interview on 12/12/2025 at 1:59 PM, the Director of Nursing stated according to the facility policy, 1:1 Supervision, required distance meant monitoring the resident at a safe distance and the resident would remain within eyesight of staff. The supervision was dependent upon the situation and resident, for example, if a resident had a nothing by mouth order and was observed drinking water from their bedroom sink, then closer supervision was needed. If a resident was a risk for elopement but was in their room with the door closed, then monitoring could be outside the room. 1:1 safety watches required a physician order and would show up on the resident care plan (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	and Kardex. Staff knew a resident was on a 1:1 by their care card. Upon review of Resident #2's care plan, they stated a 1:1 safety watch was listed on the care plan, and they were unsure why. They thought the Unit Manager might have contacted a physician. They stated Resident #2 was re-assessed the following day upon their return from the hospital, but it was not documented in their electronic medical record. They stated Resident #2 was not on a 1:1 safety watch upon return from the hospital and there was no physician order for one. 10 New York Codes, Rules, and Regulations 415.12(h)(2)