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 02/03/2026
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 0580 Level of Harm - Immediate jeopardy to resident health or safety 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during the survey, the facility failed to immediately consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status for one (1) of three (3) residents (Resident #11) reviewed. Specifically, on [DATE] between 5:00 AM and 5:30 AM, Resident #11 had labored breathing and an oxygen saturation level (amount of oxygen in the blood) of 40 percent (normal is 95 -100 percent). The oxygen flow rate was increased to 10 liters per minute without a physician order and the resident's oxygen saturation level dropped to 26 percent on 10 liters of oxygen. The physician was not notified of the resident's significant change in respiratory status. Emergency Medical Services was not called until 6:00 AM, the resident was transported to the hospital and presented to the Emergency Department at 6:30 AM with respiratory distress and a diagnosis of acute respiratory failure with hypercapnia (high levels of carbon dioxide). The resident was pronounced deceased at 8:44 AM, due to respiratory arrest. This resulted in Immediate Jeopardy to Resident #11 and placed all residents with potential significant changes in respiratory status at risk for serious harm, serious impairment, serious injury, or death. Findings include:Cross-referenced to F695: Respiratory/Tracheostomy Care and Suctioning Cross-reference to F684: Quality of CareCross-referenced to F842: Resident Records - Identifiable Information The facility policy Change in Resident Condition, last reviewed 05/2025, documented the Nurse Supervisor/Charge Nurse would notify the resident's attending physician or on-call physician when there was a significant change in the resident's physical/emotional/mental condition or a need to transfer the resident to a hospital/treatment center. The Nursing Supervisor/Charge Nurse would inform the resident's family/designated representative of any changes in the resident's condition and any changes in medical care or treatment(s). Resident #11 had diagnoses including respiratory failure, obstructive sleep apnea (interruption of breathing during sleep), and high blood pressure. The [DATE] Minimum Data Set (a resident assessment tool) documented the resident was cognitively intact, able to make themselves understood, and understood others.The [DATE] physician order documented four (4) liters of oxygen via nasal cannula, every day, every shift. The [DATE] at 7:06 AM Licensed Practical Nurse #4 progress note documented at approximately 1:00 AM, Resident #11 was observed to be resting comfortably with no signs of acute distress. Through the night, the resident remained stable and responsive. At approximately 5:00 AM, Resident #11 was found to have labored respirations and appeared minimally responsive to verbal stimuli. Oxygen saturation level was 40 percent on four (4) liters oxygen via nasal cannula. The supervisor was immediately notified and came to assess at bedside and changed the nasal cannula to an oxygen mask. Oxygen saturation levels were checked again using three (3) separate oximeters (measures oxygen saturation) simultaneously to verify accuracy. The readings obtained were 42 percent, 43 percent, and 26 percent with increased labored breathing. The supervisor was again updated with recommendation to send to Emergency Department due (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to the resident's worsening condition. Oxygen therapy was escalated to ten (10) liters via non-rebreather mask using the portable oxygen tank. Upon Emergency Medical Services arrival, Resident #11 became unresponsive and was transported to the hospital. There was no documented evidence that the medical provider was notified when the resident had a significant change in respiratory status.The [DATE] at 6:59 AM Registered Nurse #7 progress note documented they received a report from Licensed Practical Nurse #4 the resident's oxygen saturations were 42 percent and 43 percent, the resident was unresponsive, and vital signs were unable to be taken. Registered Nurse #8 assessed the resident and Licensed Practical Nurse #4 sent the resident to the hospital. Registered Nurse #7 notified Nurse Practitioner #44 (time not documented). The transfer from facility report dated [DATE] at 5:58 AM documented the reason for transfer was low oxygen saturation level of 45 [percent].The [DATE] at 6:39 AM Hospital Emergency Department provider notes documented the patient was responding to pain only. The physical exam documented respiratory distress present, with agonal breathing, was currently on 15 liters of oxygen with oxygen levels in the 90's and condition was critical. Resident #11 was pronounced deceased at 8:44 AM. During an interview on [DATE] at 11:24 AM, Health Care Proxy #11 stated they did not receive any calls from the facility about the resident's change of condition and that the resident was sent to the hospital. During an interview on [DATE] at 12:02 PM, Licensed Practical Nurse #19 stated when there was a change in a resident's condition, the certified nurse aide would report it to them. Licensed Practical Nurse #19 would then check the resident, get vitals, and contact the licensed practical nurse manager or the supervisor. They stated any change in condition related to problem with breathing was always an urgent matter. If the resident had oxygen levels in the 40's they should check to make sure the resident was on the correct amount of oxygen per the order and would then contact the supervisor. They stated they would call the medical provider if no one from nursing was available and the nurse manager or supervisor was responsible for notifying the family of a change in condition. During an interview on [DATE] at 12:10 PM, Licensed Practical Nurse #20 stated when there was a change in a resident's condition, the Certified Nurse Aide would take the resident's vitals and report to them. They would check the resident and tell the licensed practical nurse supervisor, who checked the resident and called the nurse practitioner. Respiratory distress meant the resident was having a hard time breathing. They would check the resident's oxygen, respirations, and oxygen saturation level, and would administer a breathing treatment or inhaler if there was an order. They would then notify the registered nurse manager or licensed practical nurse manager, who would call the nurse practitioner or physician. The nurse manager called the family when there was a change in condition. During an interview on [DATE] at 12:20 PM, Licensed Practical Nurse #21 stated for a change in a resident's condition they should tell the registered nurse manager or the supervisor, who would then assess the resident and call the medical provider. The registered nurse, or supervisor was responsible for notifying the medical provider of any change in condition. During an interview on [DATE] at 3:51 PM, Registered Nurse #8 stated they were the nursing supervisor during the night shift on [DATE], from 11:00 PM to 7:00 AM. They recalled Resident #11's oxygen saturation level was 88 percent, could not get the resident up to 90 percent, and ended up sending the resident out to the hospital. They stated they were already in the process of sending the resident out to the hospital when Licensed Practical Nurse #4 nurse called them and told them to send the resident to the hospital. They stated the resident's oxygen saturation level dipped down to 45 percent and they called 911. They stated they forgot to write a note about the resident's change in condition. They did not immediately call 911 because they were trying to do all they could to get the resident's oxygen saturation level up and they were monitoring the resident. They stated Licensed Practical Nurse #4 (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	monitored the resident and kept in touch with them. They stated they did not call the nurse practitioner. They felt it was an emergency and took it upon themselves to call 911. They stated they probably should have sent the resident to the hospital sooner. The family was supposed to be called when there was a change in condition, and they forgot to call the family. During an interview on [DATE] at 3:56 PM, Licensed Practical Nurse #4 stated on [DATE], between 4:30 AM and 5:00 AM, Certified Nurse Aide #15 urgently reported to them Resident #11 was not breathing right and was labored. They stated they went right to the resident, and Resident #11 was minimally verbally responsive. The resident could say their own name and was labored in their breathing.? Licensed Practical Nurse #4 stated resident's oxygen level was 40%, they then notified Registered Nurse #8, who came to the resident's room and told them to get an oxygen face mask. They stated Registered Nurse #8 left the room upon their return. The resident was still having labored breathing, and they put three (3) different pulse oximeters on the resident at the same time, using different fingers on both hands. The readings were 42%, 43%, and 26%, the resident was minimally responsive and was lethargic (sluggish, unusual decrease in consciousness). They called Registered Nurse #8 to report the oxygen saturation readings and then put the resident on the portable oxygen tank at ten (10) liters with a non-rebreather mask. They stated Registered Nurse #8 did not instruct them to put the resident on (ten) 10 liters of oxygen. Licensed Practical Nurse #4 put the resident on ten (10) liters because the resident's oxygen level was 26% on four (4) liters, and it scared them that the resident was that low. They stated they told Registered Nurse #8 what the readings were and needed to send the resident out to the hospital. Licensed Practical Nurse #4 stated they checked vital signs and wrote them on a cheat sheet. They stated they did their best to help the resident. They stated they saw Emergency Medical Services arrive and went into the resident's room after them. Licensed Practical Nurse #4 stated the resident was not responding at all at that time. During an interview on [DATE] at 2:30 PM, Registered Nurse #7 stated the only reason they wrote the note about Resident #11 on [DATE] was because Registered Nurse #8 left the building on [DATE], and there was no communication from them. They said they saw Emergency Medical Services transporting the resident out of the building. They talked to Licensed Practical Nurse #4 and told them to write a note. Registered Nurse #7 called the provider to let them know the resident was being sent to the hospital. They were not aware the resident was in respiratory distress because Registered Nurse #8 did not tell them about it. Registered Nurse #7 stated they were a supervisor and split the floor with Registered Nurse #8. They stated it was unacceptable for Registered Nurse #8 to not call the provider. Registered Nurse #7 stated they did not call the resident's family. During an interview on [DATE] at 11:47 AM, Licensed Practical Nurse #5 stated they worked the day and evening shift on [DATE]. They went into the resident's room (time unknown) and the resident's family was present. Resident #11 said they felt like they could not catch their breath. They left the room to get a pulse oximeter, returned and oxygen level was 92-93 percent, which was the resident's usual level. They changed the oxygen tubing and the humidified air water bottle. Because the resident was still having issues, they told the supervisor on the unit, Licensed Practical Nurse #80, and they called Respiratory Therapy. Licensed Practical Nurse #5 recalled the oxygen concentrator being set at four (4) liters or whatever the order was. They stated oxygen checks were done every shift. They stated they did not write a progress note and said Licensed Practical Nurse #80 would have entered a note. During an interview on [DATE] at 11:56 AM, Licensed Practical Nurse #80 stated the protocol for a change in condition was the licensed practical nurse would notify the registered nurse, who assessed the resident and called the provider to get orders. If a resident's oxygen level was 40 percent, they should call 911 or at the very least call a Code Blue, which was for (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	non-life-threatening situations but would get assistance right away. During an interview on [DATE] at 12:35 PM, Director of Nursing #1 stated Licensed Practical Nurse #4 followed protocol by calling Registered Nurse #8 to get the assessment. They stated Registered Nurse #8 should have called 911 immediately when the resident's oxygen was in the 40's and called the provider afterwards. When the resident's oxygen was in the 80's and was minimally responsive, at the very least they should have called the provider who probably would have sent the resident out at that point. The Medical Director preferred to be called prior to sending a resident to the hospital but in an emergency, the resident was to be sent out. They stated it was their understanding that Registered Nurse #8 called the family, and it would have been written in their note they started to write at 5:57 AM but did not save. During an interview on [DATE] at 10:36 AM, Medical Director #1 stated nursing staff knew they were to call Medical Director #1 when they needed to send a resident to the hospital, and if it was emergency they were to call 911. Not calling the provider or 911 immediately, was a delay in treatment. During an interview on [DATE] at 2:08 PM, Administrator #1 stated communication was extremely important. For any change in condition, they would want the registered nurse supervisor and the medical provider to be notified. Immediate Jeopardy was issued to the Administrator on [DATE] at 3:30 PM.? Facility Immediacy Removal Plan submitted on [DATE] at 6:30 PM was approved. Immediate Jeopardy was lifted effective [DATE]. The facility's immediacy removal actions included the following: All residents on oxygen had a pulse oximetry reading completed and any results deviating from the resident's baseline had a registered nurse assessment and physician notification immediately via telephone by the end of the evening shift on [DATE].Education for licensed nursing staff was implemented immediately on the Change in Resident Condition Policy requiring documented physician notification immediately via telephone for all significant changes in resident condition.All oncoming licensed nursing staff would be educated on the Change in Condition Policy, with the intent to have 100% of staff educated by midnight on [DATE].As of [DATE], 90% of licensed nursing staff were educated. 10 New York Codes, Rules and Regulations 415.3(e)(2)(ii)(b)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interviews conducted during the survey, the facility failed to ensure residents were free from abuse for one (1) of three (3) residents reviewed (Resident #1). Specifically, Resident #1 had a history of verbal behaviors of using racial slurs directed at others and had multiple physical behaviors directed toward others, including the following:-on 09/10/2025 Resident #1 threw coffee at staff, hitting another resident. -on 09/30/2025, Resident #1 hit Resident #3 in the face. -on 11/10/2025, Resident #1 refused medications and started swinging at staff. -on 12/24/2025, Resident #1 threw a glass vase at staff. -on 12/25/2025, Resident #1 hit Resident #2 in the head with a wheelchair leg rest. There was no documented evidence effective/adequate interventions were put into place after each incident to protect residents from potential abuse by Resident #1. The facility's failure to protect residents from abuse resulted in potential for harm that is Immediate Jeopardy and Substandard Quality of Care and placed all 456 residents in the facility at risk for the likelihood of serious harm, serious impairment, serious injury, or death.Findings include:The facility policy Care Planning/Care Conference revised 05/20/2025, documented the comprehensive care plan should describe the resident's medical, nursing, physical, mental and psychosocial needs and preferences and how the facility would assist in meeting needs and preferences. Care plans were to be updated/initiated at the time of any change in the resident's status, needs, goals and/or interventions. Care plans were to be reviewed and revised as appropriate upon readmission, quarterly, annually and with any significant change. The facility policy Prevention of Abuse, Neglect, Involuntary Seclusion and Misappropriation of Property, revised 05/2025, documented it was the policy of the facility to assure that all staff was familiar with the prevention of abuse, neglect, involuntary seclusion and misappropriation of property. The facility would investigate and report all allegations of abusive conduct. The facility would prevent further abuse of the allegedly abused residents while the investigation was in progress. In addition to orientation, all employees shall be in-serviced annually regarding the appropriate interventions for dealing with aggressive residents. Resident #1 had diagnoses including Alzheimer's disease and bipolar disorder (extreme shifts in mood) with psychotic (disconnection with reality) features. The 10/02/2025 Minimum Data Set (a resident assessment tool) documented the resident's cognition was moderately impaired and they had no behavioral symptoms during the assessment period. There was no documented evidence of a behavioral care plan prior to 12/25/2025. The 09/10/2025 at 2:20 PM Registered Nurse Supervisor #7 progress note documented staff reported the resident threw coffee on staff, hitting another resident seated at the table. They tried to talk to the resident about throwing the coffee, the resident did not want to continue speaking about their behavior and they used excessive profanity toward staff and residents. Medical staff were notified with a new order for labs and a valproic acid (Depakote, anticonvulsant medication used as a mood stabilizer) level. There was no documented evidence of an incident report for the 09/10/2025 behavior of throwing coffee; no documented evidence of a root cause analysis for the resident's behaviors to determine appropriate interventions; and no documented evidence the resident's care plan was reviewed/updated regarding behavioral symptoms. The 09/11/2025 laboratory report documented the valproic acid level was low at 19.6 micrograms per milliliter (normal range 50-100 micrograms per milliliter, indicating the drug concentration in the blood was low and the medication dose may require an adjustment).The 09/30/2025 at 5:45 PM Incident Report completed by Registered Nurse #2 documented that on 09/30/2025, Resident #1 had a negative interaction with Resident #3. The 10/01/2025 Investigative Summary completed by the Director of Investigations and attached to the 09/30/2025 Incident Report documented Resident #3 attempted to remove food from Resident #1's plate (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	and Resident #1 hit Resident #3's cheek resulting in light redness. Corrective action was Resident #3 was encouraged to remain seated during meals. There was no documented evidence Resident #1's care plan was reviewed/updated regarding them hitting Resident #3 or interventions to avoid recurrence. Nursing progress notes from 11/05/2025 to 11/10/2025 documented Resident #1 was refusing medications including Depakote, using racial slurs, and was physically aggressive towards staff. The 12/23/2025 at 6:15 PM Investigative Summary completed by Registered Nurse Investigator #3 documented Resident #1 was attempting to clean up the table during mealtime when they were punched in the mouth by Resident #2. Resident #1 sustained a loose lower front tooth. Interventions were put into place for Resident #2 including 1:1 supervision, initiation of Depakote and a psychiatric consult. On 12/23/2025, Resident #1's care plan was updated with the potential to be abused. The 12/24/2025 at 12:03 PM Licensed Practical Nurse Assistant Manager #4 progress note documented Resident #1 attempted to throw a glass vase at staff and used racial slurs. Resident #1 was redirected to their room. The provider saw the resident and the provider would review Depakote orders and change the dose. The resident was now calm. The 12/24/2025 Nurse Practitioner #4 note documented they followed up with Resident #1 after they were punched in the mouth. One (1) loose tooth was noted. The plan was to refer the resident to dental and increase the Depakote dose.There was no documented evidence of a physician or practitioner order to increase Depakote. The 12/25/2025 Incident Report and nursing note completed by Registered Nurse Supervisor #6 documented Resident #1 hit Resident #2 in the head with a wheelchair leg as Resident #2 ambulated down the hallway with their 1:1 staff. Resident #2 sustained redness to their forehead and neurological checks were normal. Medical was aware and the care plan was in place and ongoing. Four (4) wheelchair legs were found in Resident #1's room and were removed. The 12/25/2025 at 9:12 PM, Licensed Practical Nurse #1 progress note documented Resident #1 hit Resident #2 in the forehead with a wheelchair leg rest from their wheelchair. When they asked Resident #1 why they hit Resident #2, the resident stated they wanted Resident #2 to pay for the teeth they knocked loose, and every time they saw Resident #2, they were going to kick their ass. On 12/25/2025, Resident #1's comprehensive care plan was updated with potential to abuse others. One (1) intervention was added to include redirect the resident. The 12/29/2025 physician order documented Resident #1's Depakote was increased to 500 milligrams twice daily.During an interview on 01/08/2026 at 2:28 PM, Certified Nurse Aide #9 stated Resident #1 had issues with larger females, if they thought they were someone from their past, or if they suspected staff were sleeping with their spouse. The resident could be violent and recently threw a vase. Resident #1 liked to clean up tables when residents were finished eating and was doing so at the table they sat at with Resident #2, who punched Resident #1 in the mouth. They believed Resident #1 recalled the incident from 12/23/2025 because when they were walking with Resident #2, Resident #1 exited their room and struck Resident #2 with a wheelchair leg rest. They intervened and separated the residents. They were not sure what was being done about Resident #1's behavior. They knew they needed to monitor Resident #1 and keep them away from certain residents but did not recall a specific behavior plan. During an interview on 01/09/2026 at 11:26 AM, Licensed Practical Nurse Assistant Manager #4 stated Resident #1ad dementia and had a good memory. The resident could be verbal at times and was not usually physically aggressive. When a provider wanted a medication ordered, the provider usually told them verbally, however, providers could enter their own orders in the resident's record. On 12/24/2025, they were with Resident #1 when Nurse Practitioner #5 evaluated the resident and said they would review the record. After the 12/24/2025 incident with the vase, the resident was brought back to their room, they denied the incident at first and then stated they were sorry. They stated they could not implement or edit care plans and could not perform (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	assessments. As Licensed Practical Nurse Assistant Manager #4 reviewed the record, they stated Resident #1 had no care plan for behaviors prior to 01/09/2026. The registered nurse would have been responsible to implement a behavior care plan. During an interview on 01/09/2026 at 3:39 PM, Licensed Practical Nurse #1 stated Resident #1 had some cognitive impairment and seemed to remember things although acted like they did not remember. The resident had behaviors and that was why they were on the dementia unit. The resident had an incident on 12/23/2025 with Resident #2. Resident #1 started clearing plates at the table, Resident #2 became agitated and punched Resident #1. Resident #1 was known to hold resentment and said Resident #2 was going to pay for their dental bill. On 12/25/2025, they were passing medications and saw Resident #1 hit Resident #2 with the wheelchair leg. No changes were made to Resident #1's care plan and staff on the unit continued to monitor Resident #1. The unit currently did not have a manager. Resident #1 had no further incidents since 12/25/2025. During an interview on 01/09/2025 at 12:17 PM, Registered Nurse Supervisor #7 stated they believed the care plan got updated immediately after a resident displayed behavioral concerns and any registered nurse could update the care plan. On 09/10/2025, the resident directed the thrown coffee at staff, and it consequently hit a resident nearby. The other resident had no injury. They believed an Incident Report was required though not sure if they filled one out. The care plan should have been updated, and they were not sure why they did not update it. During an interview on 01/12/2026 at 10:06 AM, Registered Nurse #2 stated on 09/30/2025, they believed they updated the resident's care plan. When they looked back at the care plan in the electronic record, they did not see any updates during that time. They should have put a behavior care plan in place after the incident and was not sure why they did not. They were not aware of any resident behaviors prior to 09/30/2025. They stated they would expect the resident's care plan to be updated on 12/25/2025 after Resident #1 hit Resident #2 with a wheelchair leg rest and it was not done timely. During an interview on 01/12/2026 at 11:00 AM, Quality Assurance Registered Nurse #8 stated they updated care plans, sometimes daily or based on team meetings and did so for the whole building. The care plan should be updated for any identified changes or when they found something during an audit. A resident-to-resident altercation required a care plan update. If they were aware of an altercation during a team meeting, they would update the plan, otherwise the nurse manager would update it. On 12/25/2025, the supervisor should have updated the care plan after the incident. On 01/12/2026, Registered Nurse Supervisor #6 was unable to be reached for an interview.During an interview on 01/12/2026 at 2:05 PM, the Medical Director stated they expected all residents with behaviors to have a care plan. They were not aware of the resident's incidents when they occurred, however, could see in the record that a provider was notified each time.During an interview on 01/12/2026 at 4:47 PM, Nurse Practitioner #5 stated they were notified of the recent incidents involving Resident #1 throwing a glass vase at staff and hitting Resident #2 with a wheelchair leg rest. They felt these were isolated incidents. They saw Resident #1 on 12/24/2025 after the incident with Resident #2. Resident #1 was very upset, wanted to know who was going to pay their dental bill and they were able to calm the resident down. They were reviewing the resident's medications to see if they needed adjusting and documented to increase Depakote however did not increase Depakote until 12/29/2025 because they wanted to discuss with the team first. When they did change the Depakote dose, it was more for the resident's increased paranoia due to dementia, not their bipolar depression. There was no therapeutic level for Depakote unless the medication was taken for seizures, not for behaviors. They did Depakote levels for the resident to monitor for toxicity. If Depakote was at a non-therapeutic level, it would not cause an increase in behaviors. They did not have an opinion about care planned interventions and stated that was up to nursing. During an interview on (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	01/13/2026 at 12:30 PM and 5:10 PM, the Director of Nursing stated when there was an incident between residents, the residents were separated, the supervisor notified, the registered nurse assessed, and the Director of Nursing or the Administrator were notified. The registered nurse that assessed the resident was responsible to review/revise the care plan and they expected the care plan reviewed/revised within the shift. The Interdisciplinary Team did a thorough review into root cause analysis and determined if a resident should be on 1:1 supervision based on previous aggressive incidents and if interventions were not immediately working. On 09/10/2025, the incident with the coffee was incidental, the coffee was cold, and the other involved resident was not injured. Resident #1 had labs done on 09/15/2025 and the provider documented they were reviewed; the resident was at baseline and to continue to monitor. They expected the care plan to be updated if the behavior continued and current interventions did not work. If the resident returned to baseline and did not continue to need interventions, then they would not expect new interventions to be added. On 09/30/2025, when the resident punched Resident #3 in the face, based on the investigation, Resident #3 attempted to take Resident #1's food. There was redness noted to Resident #3's cheek, no pain and both did not recall the incident. Resident #3's care plan was updated to encourage to be seated at meals. They did not see any interventions added to Resident #1's care plan. They believed Resident #1 reacted because Resident #3 invaded their personal space. Staff knew how to care for Resident #1, but it would have been helpful to have the care plan updated after this incident and the care plan was not updated. The facility protected other residents from Resident #1 after the incident by notifying the medical provider and reviewing the incident the next day. Pain was ruled out as a contributing factor at the time of the incident. On 10/01/2025, Nurse Practitioner #5 saw Resident #1 nd documented the resident was at baseline and that gave the facility a level of comfort and safety for other residents. After the 12/23/2025 incident with Resident #2, Resident #2 was put on 1:1 related to several prior incidents and history of aggression. They believed Resident #2 had a friend of the opposite sex seated at the table and that is what triggered them to punch Resident #1 in the mouth. Resident #1's care plan was updated on 12/23/2025 with potential to be abused and that was helpful. On 12/24/2025, when Resident #1 threw a vase at staff, they typically did not do an incident report for something like this. The resident was seen by Nurse Practitioner #5 and noted no increased behaviors. If the resident was easily redirectable and the behavior was corrected after the 12/24/2025 incident, then they would not have expected the care plan be updated. On 12/25/2025, 1:1 supervision was not considered for Resident #1 because looking back at the previous incident on 12/23/2025, Resident #2 was the aggressor, and they were more concerned that Resident #2 would retaliate. The care plan was not updated after because Resident #1 was easily redirectable and that was appropriate. The facility protected other residents from Resident #1 by having Resident #1 seen by the nurse practitioner who documented the resident's behavior returned to baseline. After being hit by Resident #2, Resident #1 was upset and had a lucid moment of Resident #2 hitting them and had since returned to baseline. The facility reported incidents to New York State Department of Health following F609 regulation related to abuse. The 09/30/2025 incident was not reported because there was no injury, no pain and no mental anguish noted. During an interview on 01/14/2026 at 12:40 PM, the Administrator stated they learned about incidents by attending morning report, reading records, and attending the wellness committee. If there was an incident report for resident-to-resident abuse, they were involved. Incidents were communicated to them by the nursing supervisor or by the Director of Nursing. They were somewhat familiar with Resident #1 and knew they had behaviors. They were aware of all the incidents with Resident #1. Staff knew how to manage the resident through the care plan. Medical was on top of Resident #1's care and (continued on next page)

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	335184	A. Building B. Wing	02/03/2026

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	made medication changes. In response to the 09/10/2025, 09/30/2025 and 12/25/2025 incidents, the Administrator stated the resident went from October to November without behaviors, the resident attempted to throw a vase and was not sure if it hit staff. They did not have a role in updating the care plan and that was the responsibility of nursing. There were a lot of long-term staff on the unit that were very familiar with the resident. Those long-term staff reported to newer staff verbally through report and knew what redirect meant in the care plan. The staff were to try non-pharmacological interventions first. They were not sure if the resident was seen by psych services after the incidents. After the 09/30/2025 incident, they looked at the dining room, the ambiance, added more supervision with aides, nursing and therapeutic technicians. The 09/30/2025 incident, the paperwork was not perfect, however, since implementing dining room changes, behaviors for all residents had been better. 10 NYCRR 415.4(b)(1)(i)____I Jeopardy was identified and the facility Administrator notified on 01/14/2026 at 4:09 PM. Immediate Jeopardy was removed on 01/15/2026 at 5:30 PM prior to survey exit based on the following corrective actions: -On 01/13/2026 Resident #1 was assessed by social work, medical, nursing, and a psych referral ordered. Pharmacy reviewed the resident's medications.-Resident #1's care plan was revised and included 1:1 monitoring. The plan would be reviewed and revised as needed. -On 01/14/2026, a complete hazard sweep was completed to ensure no objects could be used as weapons. -Staff communication included a shift report indicating the resident's supervision level. -All residents with a resident-resident encounter within the last 90 days had their care plans reviewed and revised as necessary with appropriate interventions in place. -As of 01/15/2026 at 12:20 PM, 96.5% of the facility staff had received education. -Understanding and retention of education for staff was verified by interviews. Staff were able to report content of education and confirmed the day they received the education.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record reviews and interviews, the facility failed to ensure incidents of abuse were reported to the State Agency as required for one (1) of three (3) residents (Resident #1) reviewed. Specifically, on 09/10/2025 Resident #1 threw coffee at staff and subsequently hit another resident seated at the table; on 09/30/2025 Resident #1 hit Resident #3 on the cheek when Resident #3 attempted to take food from Resident #1's plate. The facility failed to report the resident to resident altercations to the New York State Department of Health as required. Findings include: The 09/2024 revised facility policy, Reporting and Monitoring Accidents and Incidents, documented the Director of Nursing, Assistant Director of Nursing, Director of Investigations or designee was responsible to review all incidents for alleged abuse, mistreatment or neglect, injury of unknown origin or resident elopement. All incidents involving alleged abuse, mistreatment or neglect, injury of unknown origin, misappropriation of resident property, or resident elopement, must be reported to Administration immediately. The 05/2025 revised facility policy, Reporting and Monitoring Accidents and Incidents, remained the same as the 09/2024 version with the addition of Assistant Administrator as a policy approver. The 10/18/2022, Dear Administrator Letter DAL NH 22-20, regarding facility incident reporting system documented the changes in reporting of nursing home facility incidents as detailed by the Center of Medicare and Medicaid Services in memo, QSO-22-19-NH. The guidance included revised facility reported incident requirements that require nursing home providers to send their final facility investigation reports to the New York State Department of Health no later than five (5) days after the incident or accident. Information related to facility incident reporting could be found in Chapter 5 of the State Operations Manual. Reportable Incidents include, but are not limited to: abuse, neglect, mistreatment and exploitation; misappropriation; injury of unknown origin; physical environment incidents (ex. fire, loss of services); elopement; and death not due to natural causes. In addition to an initial facility incident report that must be submitted following reporting timelines, nursing homes, effective October 24, 2022, must submit to the Department the results of the facility investigation, called Investigation Summary Report, within five (5) days of the incident occurrence. Resident #1 had diagnoses including Alzheimer's disease and bipolar disorder (extreme shifts in mood) with psychotic (disconnection with reality) features. The 10/02/2025 Minimum Data Set (a resident assessment tool) documented the resident's cognition was moderately impaired and they had no behavioral symptoms during the assessment period.The 09/10/2025 at 2:20 PM Registered Nurse Supervisor #7 progress note documented staff reported the resident threw coffee on staff, hitting another resident seated at the table. They tried to talk to the resident about throwing the coffee, the resident did not want to continue speaking about their behavior and they used excessive profanity toward staff and residents. Medical staff were notified with a new order for labs and a valproic acid (Depakote, anticonvulsant medication used as a mood stabilizer) level. There was no documented evidence of an incident report for the 09/10/2025 behavior of throwing coffee or that the incident was reported to the New York State Department of Health.The 09/30/2025 at 5:45 PM Incident Report completed by Registered Nurse #2 documented that on 09/30/2025, Resident #1 had a negative interaction with Resident #3. The 10/01/2025 Investigative Summary completed by the Director of Investigations and attached to the 09/30/2025 Incident Report documented Resident #3 attempted to remove food from Resident #1's plate and Resident #1 hit Resident #3's cheek resulting in light redness. There was no documented evidence the 09/30/2025 resident to resident altercation between Residents #1 and #3 and was reported to the New York State Department of Health.During an interview on 01/13/2026 at 12:30 PM and 5:10 PM, the Director of Nursing stated when there was an incident between residents, the Director of (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing or the Administrator were notified. On 09/10/2025, the incident with the coffee was incidental, the coffee was cold, and the other resident involved was not injured. On 09/30/2025, when the resident punched Resident #3 in the face, based on the investigation, Resident #3 attempted to take Resident #1's food. There was redness noted to Resident #3's cheek, no pain and both did not recall the incident. The facility reported incidents to New York State Department of Health following F609 regulation related to abuse. The 09/30/2025 incident was not reported because there was no injury, no pain and no mental anguish noted. During an interview on 01/14/2026 at 12:40 PM, the Administrator stated they learned about incidents by attending morning report, reading records, and attending the wellness committee. If there was an incident report for resident-to-resident abuse, they were involved. Incidents were communicated to them by the nursing supervisor or by the Director of Nursing. 10 NYCRR 415.4(b)(1)(i)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interviews and record review conducted during the survey, the facility failed to ensure allegations of neglect were thoroughly investigated for one (1) of three (3) residents (Resident #2) reviewed. Specifically, on 02/24/2025, Resident #2 left the facility undetected, was last seen by staff at 2:00 PM, and their absence was not discovered until 5:45 PM. Resident #2 left the facility without their required oxygen and did not receive their medications or evening meal as ordered. There was no documented evidence of a thorough investigation when Resident #2 eloped from the facility on 02/24/2025. Findings include:Cross reference to F689: Free of Accident Hazards/Supervision/Devices and F 600 Free from Abuse and NeglectThe facility policy Reporting and Monitoring Accidents and Incidents revised 09/2024, documented to report and investigate any accident/incident involving a resident of the facility to rule out or report abuse, mistreatment or neglect as a cause of the incident, to the New York State Department of Health. All incidents would be reviewed for alleged abuse, mistreatment or neglect, injury of unknown origin, or resident elopement. The Director of Nursing, Assistant Director of Nursing, Director of Investigations or designee was responsible persons for that procedure. The facility policy Prevention of Abuse, Neglect, Involuntary Seclusion, and Misappropriation of Property revised 05/2025 documented the definition of neglect was the failure of the facility, its employees or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish or emotional distress. All incidents of potential abuse, neglect or misappropriation of resident property shall be investigated. Resident #2 had diagnoses including diabetes, pneumonia, protein-calorie malnutrition, cocaine dependence, opioid dependence, other psychoactive substance abuse with psychoactive substance-induced mood disorder, suicidal ideations, personal history of suicidal behavior, noncompliance with medical treatment and regimen, anxiety disorder, and acute respiratory failure. The 02/17/2025 admission Minimum Data Set (a resident assessment tool) documented the resident was admitted from an acute care hospital.The 02/17/2025 at 2:30 PM Elopement Risk Assessment completed by Registered Nurse #30 documented a score of zero (0), the). The resident was not independently mobile with or without assistive devices. The 02/17/2025 at 2:38 PM admission Nursing Assessment completed by Registered Nurse #30 documented the resident was alert and oriented, received two (2) liters of oxygen, had diminished lung sounds, required supervision with meals, required limited assistance with toileting, and had a history of falls. The Comprehensive Care Plan initiated 02/18/2025 documented the resident required partial/moderate assistance for transfers; had compromised respiratory status and had oxygen therapy in place; was an elopement/wandering risk and would remain safely in the facility and staff were to observe for verbalizations of desire to leave; and had a history of suicide attempts. The 02/24/2025 at 11:16 PM 911 audio file documented Resident #2 walked/snuck out of the building on foot sometime on the evening shift. The caller stated they were Registered Nurse #8. Resident #2 had mental or health concerns that included anxiety, depression, opioid dependence, and suicidal behaviors and ideations. They did not know when the resident left the building as they were third party to the information and just coming into work for the night shift.During an interview on 12/22/2025 at 1:32 PM, Resident #2 stated on 02/02/2025 they told someone on the seventh floor they were leaving and the staff member stated, yeah, whatever. They had their bags packed and used a wheelchair with oxygen on it to get to the lobby. They walked out the front door with the overhang, with their bags in hand. They walked off the property and were picked up along the roadway by a stranger. They had to leave their oxygen behind as they could not carry it and had difficulty breathing when they were picked up. No one attempted to stop them, ask where they were going, or request that they sign out when they left through the main door from the lobby. The facility contacted them a day or so (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	later and had a staff member meet them at Friend #28's house. They were told they had to sign papers the staff member brought, but they were not explained to them, and they did not know they signed against medical advice papers. The Facility Investigation was requested on 12/08/2025 at 11:10 AM, at which time the facility reported there were no facility investigations for Resident #2. During an interview on 12/10/2025 at 12:06 PM, Director of Nursing #1 stated Resident #2 departed the facility on 02/24/2025 at 2:10 PM based on review of camera footage. They did not know if the resident left with anyone or how they left the facility property. Director of Nursing #1 stated Resident #2 departed the facility against medical advice, and they did not know when they left the facility. Director of Nursing #1 stated the facility contacted emergency services to complete a wellness check for all residents that left against medical advice. There was no documented evidence the resident left against medical advice on 02/24/2025. The 03/04/2025 Facility Investigation was provided on 12/10/2025 at 01:15 PM and included: -Nursing Discharge Against Medical Advice documented Resident #2's name, dated 02/24/2025 at 2:30 PM. The document was signed by Resident #2, witnessed by Director of Social Work #1, and dated 02/25/2025 (one day after the elopement). The reason for leaving against medical advice was did not want to stay at facility.-The 02/24/2025 statement by Licensed Practical Nurse #14 documented they had last seen the resident days before. They stated they did not have any clothes, so Licensed Practical Nurse #14 brought clothes for the resident. They went straight to the resident's room at 2:45 PM, and they were not there. The roommate, who was of sound mind, stated they visited friends on the other floors. They checked back around 3:4 PM [sic], then again at 5:45 PM. They called the supervisor and initiated all-calls. Two (2) all calls were done and a Code White. They documented they had not seen the resident during the shift. At the time of the incident, they searched other floors, went to the first floor and spoke with security, involved floor aides and supervisors. They notified Registered Nurse #26 and Nurse #40.-The 02/24/2025 statement by Certified Nurse Aide #41 documented they did not see the resident for the entire shift. They did not see the incident happen, and they did not provide care or assistance to the resident during the shift.-The 02/24/2025 statement by Certified Nurse Aide #43 documented they had not seen the resident for the entire shift.-The 02/24/2025 at 10:41 [PM] statement by Certified Nurse Aide #42 documented they did not provide care or assistance to the resident during their shift. They did not see the incident happen.-The undated statement by Director of Recreation Therapy #33 documented yesterday in the afternoon around 12:00 - 2:00 PM, they discovered a wheelchair with an oxygen tank hooked up to the back of it, in the elevator. There was a staff member in the elevator who asked if there was an owner to the wheelchair that was left behind. There was a name tag hooked to the wheelchair. They brought the wheelchair down to the front desk, where they left it with security to help find the owner. There was no documented evidence that information was obtained from the receptionist, security, or day shift staff regarding Resident #2's elopement. There was no documented evidence of a thorough investigation to determine how the elopement occurred. During a telephone interview on 12/10/2025 at 2:02 PM, Licensed Practical Nurse #14 stated they recalled the resident. They had worked with them a few times. They came in a little early on 02/24/2025 and brought clothes in for Resident #2. When they entered the resident's room at 2:45 PM on 02/24/2025, the resident's roommate said Resident #2 was visiting with friends in the building. They returned later in the evening and Resident #2 was still not back. They did an overhead page for the resident and conducted a Code White. They stated they searched the whole building, down to the basement. Resident #2 was not located. They reported the information to their supervisor. They did not see the resident for the entire evening shift on 02/24/2025, they stated the resident must have left during the 7:00 AM to 3:00 PM shift. During an interview on 12/17/2025 at (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2:15 PM, the Director of Nursing stated the investigation was completed by the Assistant Administrator and themselves. The investigation outlined that the resident had not been in sight for the entire shift. They stated all the statements were from evening shift staff, and the resident left on the day shift. There were no statements from the front desk staff included in the investigation, and were not sure if they just got missed, as there were a lot of other reportable events that week. They did not document the review of the camera footage that was done on 02/25/2025. They did not gather statements from the nurse that called emergency services, nor the nurse that spoke with the police when they came to the facility. They did not gather statements from the Social Worker that met with Resident #2 on 02/25/2025, because they did not think they needed to. However, the location of the wellness check and the location where they met the resident were different, they did not think a statement was necessary. They could not confidently answer if all the unknowns related to Resident #2's incident were investigated. They stated they did a complete and through investigation with the pieces they had, and they could always do more. They would expect the staff to do a Code [NAME] if they could not find a resident or the resident was not where they were supposed to be, but they could not speak to why the staff did the search specifically. 10 New York Codes, Rules, and Regulations 415.4(b)(3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record reviews and interviews conducted during the survey, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for one (1) of one (1) resident (Resident #1) reviewed. Specifically, Resident #1 exhibited escalation of behavioral symptoms including resident-to-resident altercations, and physical and verbal abuse directed toward others and there was no documented evidence of a comprehensive care plan addressing the resident's behavioral symptoms with specific interventions to be implemented. Findings include:Cross Reference to F 600 Free from Abuse and NeglectCross Reference to F 609 Reporting of Alleged violations The facility policy Care Planning/Care Conference, revised 05/20/2025, documented care plans should reflect person-centered care with resident specific interventions. Care plans are to be updated/initiated at the time of any change in the resident's status, needs, goals, and/or interventions. Resident #1 had diagnoses including Alzheimer's disease and bipolar disorder (shifts in mood) with psychotic (disconnection with reality) features. The 10/02/2025 Minimum Data Set (a resident assessment tool) documented the resident's cognition was moderately impaired and they had no behavioral symptoms during the assessment period.The Comprehensive Care Plan initiated 03/13/2024 documented the resident was pleasant and cooperative; at times could become agitated with staff and peers; and had a history of using racial slurs against peers and staff. There were no interventions documented. A 09/10/2025 at 2:20 PM Registered Nurse Supervisor #7 progress note documented staff reported the resident threw coffee on staff, hitting another resident seated at the table. They tried to talk to the resident about throwing the coffee, the resident did not want to continue speaking about their behavior and they used excessive profanity toward staff and residents. Medical staff were notified with a new order for labs and a valproic acid (Depakote, anticonvulsant medication used as a mood stabilizer) level. The 09/30/2025 at 5:45 PM Incident Report completed by Registered Nurse #2 documented that on 09/30/2025, Resident #1 had a negative interaction with Resident #3. The 10/01/2025 Investigative Summary completed by the Director of Investigations and attached to the 09/30/2025 Incident Report documented Resident #3 attempted to remove food from Resident #1's plate and Resident #1 hit Resident #3's cheek resulting in light redness. Corrective action was Resident #3 was encouraged to remain seated during meals.There was no documented evidence of an updated care plan addressing the resident's behaviors exhibited on 09/10/2025 and 09/30/2025. There was no documented evidence of a care plan for the resident's potential to abuse others or potential to be a victim of abuse, or person-centered interventions.Nursing progress notes from 11/05/2025 to 11/10/2025 documented Resident #1 was refusing medications including Depakote, using racial slurs, and was physically aggressive towards staff.There was no documented evidence of an updated care plan addressing the resident's behaviors.The 12/23/2025 at 6:15 PM Investigative Summary completed by Registered Nurse Investigator #3 documented Resident #1 was attempting to clean up the table during mealtime when they were punched in the mouth by Resident #2. Resident #1 sustained a loose lower front tooth. Interventions were put into place for Resident #2 including 1:1 supervision, initiation of Depakote and a psychiatric consult.On 12/23/2025, Resident #1's care plan was updated with the potential to be abused. A 12/24/2025 at 12:03 PM Licensed Practical Nurse Assistant Manager #4 progress note documented Resident #1 attempted to throw a glass vase at staff and used racial slurs. Resident #1 was redirected to their room. The provider saw the resident and the provider would review Depakote orders and change the dose. The resident was now calm.The 12/25/2025 Incident Report and nursing note completed by Registered Nurse Supervisor #6 documented Resident #1 hit Resident #2 in the head with a wheelchair leg as (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2 ambulated down the hallway with their 1:1 staff. Resident #2 sustained redness to their forehead and neurological checks were normal. Medical was aware and the care plan was in place and ongoing. Four (4) wheelchair legs were found in Resident #1's room and were removed.The 12/25/2025 Comprehensive Care Plan documented the resident had a previous history of altercations/abusing others. The only intervention was to redirect the resident. There was no documented evidence of resident-centered interventions or measurable objectives addressing the resident's behavioral symptoms. During an interview on 01/08/2026 at 2:28 PM, Certified Nurse Aide #9 stated Resident #1 had issues with larger females, if they thought they were someone from their past, or if they suspected staff were sleeping with their spouse. The resident could be violent and recently threw a vase. Resident #1 liked to clean up tables when residents were finished eating and was doing so at the table they sat at with Resident #2, who punched Resident #1 in the mouth. They believed Resident #1 recalled the incident from 12/23/2025 because when they were walking with Resident #2, Resident #1 exited their room and struck Resident #2 with a wheelchair leg. They intervened and separated the residents. They were not sure what was being done about Resident #1's behavior. They knew they needed to monitor Resident #1 and keep them away from certain residents but did not recall a specific behavior plan.During an interview on 01/09/2026 at 11:26 AM, Licensed Practical Nurse Assistant Manager #4 stated they could not implement or edit care plans and could not perform assessments. As Licensed Practical Nurse Assistant Manager #4 reviewed the record, they stated Resident #1 had no care plan for behaviors prior to 01/09/2026. The registered nurse would have been responsible for implementing a behavior care plan.During an interview on 01/09/2026 at 3:39 PM, Licensed Practical Nurse #1 stated Resident #1 had behaviors and that was why they were on the dementia unit. The resident had an incident on 12/23/2025 with Resident #2. Resident #1 started clearing plates at the table, Resident #2 became agitated and punched Resident #1. Resident #1 was known to hold resentment and said Resident #2 was going to pay for their dental bill. On 12/25/2025, they were passing medications and saw Resident #1 hit Resident #2 with the wheelchair leg. No changes were made to Resident #1's care plan and staff on the unit continued to monitor Resident #1. During an interview on 01/09/2025 at 12:17 PM, Registered Nurse Supervisor #7 stated they believed the care plan was updated immediately after a resident displayed behavioral concerns and any registered nurse could update the care plan. On 09/10/2025, the resident directed the thrown coffee at staff, and it consequently hit a resident nearby. The care plan should have been updated, and they were not sure why they did not update it.During an interview on 01/12/2026 at 10:06 AM, Registered Nurse #2 stated on 09/30/2025, they believed they updated the resident's care plan. When they looked back at the care plan in the electronic record, they did not see any updates during that time. They should have put a behavior care plan in place after the incident and was not sure why they did not. They were not aware of any resident behaviors prior to 09/30/2025. They stated they would expect the resident's care plan to be updated on 12/25/2025 after Resident #1 hit Resident #2 with a wheelchair leg and it was not done timely.During an interview on 01/12/2026 at 11:00 AM, Quality Assurance Registered Nurse #8 stated they updated care plans, sometimes daily or based on team meetings and did so for the whole building. The care plan should be updated for any identified changes or when they found something during an audit. A resident-to-resident altercation required a care plan update. If they were aware of an altercation during a team meeting, they would update the plan, otherwise the nurse manager should update it. On 12/25/2025, the supervisor should have updated the care plan after the incident.During interviews on 01/13/2026 at 12:30 PM and 5:10 PM, the Director of Nursing stated when there was an incident between residents the registered nurse was responsible for reviewing/revising the care plan and they expected the care plan reviewed/revised (continued on next page)

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	02/03/2026

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	within the shift. On 09/10/2025, the incident with the coffee was incidental, the coffee was cold, and the other resident involved was not injured. They expected the care plan to be updated if the behavior continued and current interventions did not work. If the resident returned to baseline and did not continue to need interventions, then they would not expect new interventions to be added. On 09/30/2025, when the resident punched Resident #3 in the face, Resident #3's care plan was updated to encourage to be seated at meals. They did not see any interventions added to Resident #1's care plan. Staff knew how to care for Resident #1, but it would have been helpful to have the care plan updated after this incident and the care plan was not updated. Resident #1's care plan was updated on 12/23/2025 with potential to be abused. If the resident was easily redirectable and the behavior was corrected after the 12/24/2025 incident, then they would not expect the care plan to be updated. The care plan was not updated after the 12/25/2025 incident because Resident #1 was easily redirectable and that was appropriate. 10 New York Codes, Rules and Regulations 415.11(c)(1)

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 02/03/2026
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	

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review and interviews conducted during a survey, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one (1) of three (3) residents (Resident #11) reviewed. Specifically, on 11/25/2025, Resident #11's respiratory complaints were not appropriately addressed, and physician's orders were not followed. On 11/26/2025, Resident #11 was not adequately monitored when they exhibited respiratory distress and were left unsupervised while waiting for Emergency Medical Services arrival. This resulted in Immediate Jeopardy and Substandard Quality of Care for Resident #11 and placed all residents with potential changes in health status at risk for serious harm, serious impairment, serious injury, or death. Findings include: Findings include:Cross-referenced to F695: Respiratory/Tracheostomy Care and Suctioning Cross-referenced to F580: Notification of Changes (Injury/Decline/Room, Etc.) The undated facility policy Respiratory Care, documented the facility would provide safe and effective respiratory care services to residents with identified needs. All procedures would be performed by trained and competent licensed nursing staff in accordance with physician orders, manufacturer instructions, and applicable federal and state regulations. Oxygen therapy was a medication and required a valid physician order. Staff would verify the order including flow rate, delivery method (nasal cannula, mask, concentrator), and frequency. In the event of respiratory distress, airway obstruction, or equipment failure, staff would initiate emergency response protocols and notify the provider immediately. All respiratory care provided would be documented in the medical record, including the type of intervention, resident response, and any adverse reactions or changes in condition. Resident #11 had diagnoses including respiratory failure, obstructive sleep apnea (interruption of breathing during sleep), and high blood pressure. The 10/21/2025 Minimum Data Set (a resident assessment tool) documented the resident was cognitively intact, able to make themselves understood, and understood others. The Comprehensive Care Plan,?revised 11/06/2025, documented the resident was at risk for compromised respiratory status due to obstructive sleep apnea, pulmonary embolism (a blood clot that travels to the lungs), and not using continuous positive airway pressure machine to treat sleep apnea. Interventions included monitor resident's respiratory status: anxiety, restlessness, increased confusion, shortness of breath, dyspnea, lethargy (unusual decrease in consciousness), decreased activity, change in sputum production or change in color, character of sputum; monitor breath sounds, monitor activity tolerance, pace and space activities, provide restful calm environment, monitor vital signs, oxygen per physician order, and consult with respiratory therapist as needed. The 11/18/2024 physician order documented four (4) liters of oxygen via nasal cannula, every day, every shift. The 11/25/2025 at 6:38 PM Respiratory Therapist #6 progress note documented Resident #11 was assessed in their room during dinner in response to a nursing report of intermittent shortness of breath. The resident was alert, oriented, and in no apparent distress at the time of the assessment. Respirations were even and unlabored. The resident was educated on deep breathing techniques, including slow diaphragmatic breathing (a breathing technique to increase oxygen intake), paced inhalation and exhalation, and pursed lip breathing to promote improved lung expansion and assist in managing symptoms during episodes. The resident was encouraged to practice these exercises daily and to notify staff promptly if symptoms increased in frequency or severity. The resident verbalized understanding and was receptive to education. Oxygen saturation level was 92% (normal healthy person 95-100%) on three (3) liters of oxygen. Lung sounds were clear bilaterally (both lungs). There was no documented evidence of a registered nurse assessment when the resident was experiencing shortness of breath or documentation the resident's respiratory status was monitored. The 11/26/2025 at 7:06 (continued on next page)

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 02/03/2026

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

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	AM Licensed Practical Nurse #4 progress note documented at approximately 5:00 AM, Resident #11 was minimally responsive with labored breathing. Oxygen saturation level was 40% on four (4) liters of oxygen via nasal cannula. Licensed Practical Nurse #4 contacted Registered Nurse #8 who arrived to assess the resident. The nasal cannula was switched to a venti mask (oxygen mask). Licensed Practical Nurse #4 checked the resident's oxygen saturation again (no time documented), it remained in the 40's and the resident had increased labored breathing. Registered Nurse #8 was again updated with recommendations by Licensed Practical Nurse #4 to send the resident to the emergency department due to worsening condition. The portable oxygen tank was escalated to ten (10) liters via non-rebreather mask.There was no documented evidence of an assessment by Registered Nurse #8 or documentation that a physician was notified of the declining respiratory status. The Emergency Medical Services Patient Care Record dated 11/26/2025, documented the facility called 911 at 6:04 AM. Upon arrival the resident was unresponsive with agonal respirations (gasping, labored breathing). There were no staff present on the floor (resident's unit), and Emergency Medical Services called the fire department to assist with moving the resident. During an interview on 12/04/2025 at 11:24 AM, the resident's health care proxy stated they and another family member visited Resident #11 on 11/25/2025. The oxygen concentrator was not working and they notified staff. Another family member placed the resident on the portable oxygen tank in the room. When they left at 5:00 PM, no staff had come to address the oxygen.During an interview on 12/04/2025 at 3:56 PM, Licensed Practical Nurse #4 stated that on 11/26/2025 between 4:30 AM and 5:00 AM, they were notified by Certified Nurse Aide #15, the resident was not breathing right. When they entered the room, the resident had labored breathing. They contacted Registered Nurse #8, who came to the bedside and told them to put the resident on a face mask (for oxygen). Registered Nurse #8 did not stay in the room. They stated when they rechecked the resident's oxygen level (time unknown), it was still in the 40's. They told Registered Nurse #8 the resident needed to go to the hospital and turned the portable oxygen tank up to 10liters. They stated there were no provider orders for the 10 liters of oxygen. During an interview on 12/09/2025 at 3:51 PM, Registered Nurse #8 stated on 11/26/2025, they recalled Resident #11's oxygen level was 88%. They could not recall how much oxygen the resident was on, and they did not stay in the room. They did not call the provider as they took it upon themselves to call 911. They stated they did everything they were supposed to do and should have sent the resident to the hospital sooner. During an interview on 12/09/2025 at 4:37 PM, Respiratory Therapist #6 stated on 11/25/2025, Resident #11 complained of shortness of breath. The resident was not in any distress when they saw them. The oxygen was connected to a portable tank and they switched the resident to the oxygen concentrator and put it on three (3) liters. They did not check the resident's oxygen orders, as the resident was on three (3) liters before. During an interview on 12/11/2025 at 12:35 PM, Director of Nursing #1 stated Registered Nurse #8 should have called the provider when the resident's oxygen saturation level was in the 80s. During an interview on 12/15/2025 at 10:36 AM, Medical Director #1 stated not calling the provider or 911 immediately was a delay in care. 10 New York Codes, Rules, and Regulations 415.12 ____Immediate Jeopardy was issued to the Administrator on 01/22/2026 at 3:30 PM. Immediate Jeopardy was lifted effective 01/25/2026. The facility's immediacy removal actions included the following: All residents on oxygen had a pulse oximetry reading completed and any results deviating from the resident's baseline had a registered nurse assessment and physician notification immediately via telephone by the end of the evening shift on 01/22/2026. Any resident demonstrating respiratory distress would not be left unattended awaiting Emergency Medical Services. All resident accident and incident reports have been reviewed for the last 30 days. Any significant change in (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	status (e.g., respiratory distress, unresponsiveness, new pain not relieved), abnormal laboratory results requiring action in the past week were reviewed to ensure they were addressed and the need to alter treatment significantly or transfer the resident was reviewed. Registered Nurse #8 was re-educated on assessments and supervision on 01/08/2026. Education was implemented immediately specific to: Educated licensed nursing staff on Change in Condition Policy for significant change in respiratory status. Educated licensed nursing staff with communication with the registered nurse and proper assessment of respiratory complaints. Educated certified nursing assistants regarding communication with the licensed nursing staff regarding respiratory changes in condition and all others. Educated licensed nursing staff on following physician orders and performing within scope of practice. Educated licensed nursing staff on obtaining vital signs with change in condition. As of 01/25/2026, 90% of licensed nursing staff were educated.

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 02/03/2026

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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 0689

Level of Harm - Immediate jeopardy to resident health or safety

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 abbreviated survey the facility failed to provide adequate supervision to prevent accidents for one (1) of three (3) residents (Resident #2) reviewed for elopement. Specifically, Resident #2 who was cognitively intact and had a history of suicidal ideations, opioid dependence, and mental health disorders, eloped from the facility on 02/24/2025 at an unknown time. Resident #2 was allegedly last seen by facility staff on 02/24/2025 at 2:00 PM and the resident's absence was not discovered until 5:45 PM. The resident was contacted via telephone by law enforcement on 02/25/2025 at 12:11 AM after the facility called emergency services to report the resident missing on 02/24/2025 at 11:16 PM. The resident would not disclose their location to law enforcement and did not return to the facility. This resulted in Immediate Jeopardy and Substandard Quality of Care to Resident #2 and placed all residents identified at risk of elopement and/or leaving the facility against medical advice at risk for the likelihood of serious injury, serious harm, serious impairment, or death. Findings include:The revised 05/2011 facility policy Discharge Against Medical Advice Policy revised 05/2011 documented the facility must provide for the safest discharge possible under all circumstances. This included educating the resident/responsible party on the risks and potential consequences of the decision to leave the facility. As soon as it was apparent that a resident or family member was considering a discharge against medical advice, a discussion was initiated immediately with the resident/responsible party and interdisciplinary team to identify the motivation for the desire to leave the facility against medical advice and to attempt to resolve concerns to the extent possible. This included the failure to comply with the out on pass care plan, observation of removing personal possessions from the resident room, or verbalization of leaving [against medical advice]. Notification of the intent to leave the facility [against medical advice] made to Administrator/On-Call Administrator, Attending Physician/On-Call Physician, Nursing Administration, Social Work, and Responsible party. The resident/responsible party would be counseled regarding the possible complications of the discharge intentions such as threat to physical and/or social well-being, including concerns relating to: transfer ability, positioning, toileting needs, food and fluids, invasive or external medical devices and/or treatments, medical diagnosis/conditions that could exacerbate or require interventions, possible difficulty arranging for home care or follow up services, need to make immediate arrangements for necessary medication or equipment. Such counseling would be documented in the medical record, including the resident reaction to such. This counseling of the resident/responsible party would include the Attending Physician as soon as possible. After every effort was made to counsel the resident of the risks associated with discharge [against medical advice], the resident would be required to sign the Discharge Against Medical Advice form. If the resident refused to sign the form, the discussion would be documented on the form and signed by at least two (2) witnesses. Documentation in nurse's notes and social work progress notes would reflect the circumstances surrounding the resident's decision to discharge against medical advice, and outline the information provided to the resident to assist in the decision-making process. A physician order would be obtained for Discharge [against medical advice] The 08/01/2022 facility policy and procedure Code White/Elopement Search Policy & Procedure documented elopement was defined as the incident in which a resident successfully leaves the building unnoticed and unsupervised and enters into harm's way. Any staff that cannot account for a resident would notify the charge nurse who would notify the supervisor immediately. The nursing supervisor would inform the operator to make an announcement. Operator would announce Name of Resident, please return to unit. This would be repeated three (3) times. If

(continued on next page)

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 02/03/2026

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the resident did not respond in a reasonable period of time not to exceed 20 minutes, the charge nurse would call the operator and security, they would announce Code [NAME] Name of Resident, was wanted on unit. This would be repeated three (3) times. Administration would be notified immediately of code white (if non-business hours, the nursing supervisor would notify Administrator and Assistant Administrator). Administrator or designee would set up command post in Administrative Conference Room or [Activity Room]. This announcement would be an indication for staff that all residents were to return to their rooms and for unit staff to begin head count of all residents. The nursing supervisor would attempt to reach the resident's contact to determine if the resident went out of the building with a family member. All department head staff would be notified by an administration staff member in the event the incident occurs during non-business hours with intent of assisting with search efforts. A photograph of all residents with [wander alert device] are available under the Adventure Club tab on the [electronic medical record] dashboard. Department supervisor or director or their designee would initiate a search of their areas utilizing their unit/department search checklists. As each nursing unit and department search was completed the department supervisor or director or their designee shall provide the search checklist to Administrator at designated command post. Department supervisor or director or their designee would await further instruction from command center at this time. After checklists are complete, the assigned team, under the direction of the nursing supervisor, would search all rooms on the floor to verify the resident was not accounted for on unit/floor. If the resident has not been found, the Administrator or Assistant Administrator would determine when the appropriate outside agencies would be notified. No staff would be allowed to leave until the resident was found or approved by the Administrator. Unit Manager/Charge Nurse would complete a detailed nursing narrative note (must be completed on the same shift that the resident was found) in [the electronic medical record]. Unit Manager/Charge Nurse completed an Incident Report form in [the electronic medical record]. Record review of the aforementioned 08/01/2022 facility policy and procedure, Code White/Elopement Search Policy & Procedure, revealed there was no timeframe on when to call 911 or involve emergency services if the resident was not found. Instead, the policy documented, the Administrator or Assistant Administrator would determine when the appropriate outside agencies would be notified, and did not specify what was meant by outside agencies. Resident #2 had diagnoses including cocaine dependence, opioid dependence, other psychoactive substance abuse with psychoactive substance-induced mood disorder, suicidal ideations, personal history of suicidal behavior, noncompliance with medical treatment and regimen, anxiety disorder, and acute respiratory failure. The 03/26/2025 Minimum Data Set (a resident assessment tool)documented the resident was discharged on 02/25/2025 to home/community. A subsequent Minimum Data Set submitted 06/09/2025 documented the resident discharged on 02/24/2025 to home/community. The basic care plan initiated on 02/18/2025 documented a discharge care plan. Interventions included establishing a predischarge plan with the resident/family/caregivers and evaluate progress and revise the plan. There was no documented evidence the basic care plan initiated 02/18/2025 included supervision or elopement prevention interventions related to the resident's medical history The 02/2025 nursing care instructions documented Resident #2 was alert and forgetful at times and required three (3) liters of oxygen via nasal cannula at all times. There was no documentation of the resident's mobility status. The 02/19/2025 at 10:00 AM Three (3)-Day Meeting template completed by Social Worker #2, documented the goals were to complete short-term rehabilitation and possibly discharge to an assisted living facility. It documented Resident #2 wanted assisted living facility placement since they did not have informal support and no family/friend support. It further documented that Resident #2 was homeless and living in hotel/motel housing prior to (continued on next page)

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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	

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	admission. It documented Resident #2 had mental health diagnoses, was on substance use disorder medications, and was dependent on supplemental oxygen. An Elopement Risk Assessment completed 2/17/2025 at 2:30 PM by Registered Nurse #30 documented a score of zero (0), The resident was not independently mobile with or without assistive devices. During an interview on 12/09/2025 at 11:18 AM, Registered Nurse #30 stated they completed resident Against Medical Advice and Elopement risk assessments upon resident admission. They stated they did not recall the specific resident, as they saw so many people, but would spend 10 to 15 minutes with a resident upon admission. Registered Nurse #30 further stated that they assessed a resident's mobility based on what devices the transport agency provided to the resident for a chair transfer. If a resident scored more than five (5) for either the Against Medical Advice or Elopement assessment, they would be given a wander alert device. Registered Nurse #30 reviewed the assessments in the electronic medical record during the interview and stated Resident #2 scored more than five (5) for the Against Medical Advice risk assessment, but a wander alert device was not placed on the resident. Registered Nurse #30 stated the resident had suicidal ideations. During an interview on 12/18/2025 at 12:39 PM, Physical Therapist #35 stated Resident #2 was unsteady with mobility and had a gait deviation due to right eye blindness. On admission, they were a minimal assist where they performed 75 percent of the movement on their own. When they discharged from the facility, they were contact guard assist due to the blindness and steadiness. Physical Therapist #35 stated Resident #2 could ambulate 60 feet with a rest after each 60-foot section. They were dependent on three (3) liters of oxygen. Physical Therapist #35 further stated that Resident #2 tended to rush the movements with poor regard for safety. Cognitive deficits were also noted when teaching and showing them about mobility. They could maybe walk 100 feet but would be physically exhausted. They were unsteady to the point of falling; they would fall into the walls. There was depth perception concern due to the right eye blindness. The 02/19/2025 History and Physical progress note by Physician #3 documented that before being admitted to the facility, Resident #2 was seen at a hospital for diarrhea, fatigue, shortness of breath, and toxicology screening at the hospital completed on 02/12/2025 detected cocaine. Diagnoses included opioid dependence. Past medical history documented depression with history of psychotic features and history of suicidal ideation, epilepsy, hypothyroidism, chronic pain, nicotine dependence, chronic obstructive pulmonary disease, history of gastrointestinal bleed, cocaine use disorder, amphetamine use disorder, tetrahydrocannabinol (main psychoactive compound in cannabis) dependence, alcohol use disorder, cluster B personality traits (dramatic, emotional, erratic, and impulsive behaviors, characterized by unstable relationships, attention-seeking, grandiosity, or a disregard for others. Key traits include intense mood swings, impulsivity, difficulty with emotional control, frequent conflict, and challenges with self-image and stable connections, often leading to risky behaviors or rule-breaking), opioid use disorder, chronic abdominal pain, migraine, drug-induced constipation, retinal vein occlusion of the right eye, atherosclerotic cardiovascular disease (condition caused by plaque buildup in artery walls, narrowing them and restricting blood flow to vital organs), post-traumatic stress disorder (a mental health condition that can develop after experiencing or witnessing a traumatic event, characterized by intrusive memories; avoidance of reminders; negative changes in mood and thinking such as guilt, detachment, loss of interest; and hyperarousal of being jumpy, irritable, tense), and cataract of an eye. It further documented Resident #2 was of low weight, had lived alone, and was not mobile in their home due to weakness. It further documented Physician #3 discussed the case with the resident's occupational therapist who reported Resident #2 had poor safety awareness. Record review of the 02/2025 physician orders revealed no documented evidence for Resident #2 to leave the building or to be out-on-pass. Day of (continued on next page)

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 02/03/2026
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Elopement, 02/24/2025: The 02/24/2025 Eating/Fluid report documented the last meal consumption for Resident #2 was breakfast on 02/24/2025. The 02/2025 Medication Administration Record documented Registered Nurse #12 administered Gabapentin (a prescription anticonvulsant medication used primarily for nerve pain and to control certain types of seizures in epilepsy by calming overexcited nerve signals in the brain) to Resident #2 on 02/24/2025 at 2:00 PM. During an interview on 12/22/2025 at 1:32 PM, Resident #2 stated they did not feel welcome at the facility. The staff picked on them and did not provide care assistance when needed. They stated they told someone on the seventh floor they were leaving and the staff member responded saying, yeah, whatever. Resident #2 stated that on 02/24/2025, they packed their bags, used a wheelchair with oxygen to get to the lobby, and then walked out the front entrance with their bags in hand. Resident #2 stated no one at the facility attempted to stop them, ask where they were going, or request that they sign out when they left. They walked off property but had to leave their supplemental oxygen behind because it was too heavy to carry. Resident #2 stated a stranger who was driving had stopped to give them a ride. Resident #2 stated they had difficulty breathing when they were picked up. They did not return to their last known address and instead remained at Friend #28's house. The 02/24/2025 Incident Report - Employee Statement by Licensed Practical Nurse #14 documented they had last seen Resident #2 days before. The resident stated they did not have any clothes, so Licensed Practical Nurse #14 brought them clothes. They went straight to the resident's room on 02/24/2025 at 2:45 PM but did not find Resident #2. The roommate, who was of sound mind, stated Resident #2 would visit friends on other floors. It documented Licensed Practical Nurse #14 checked back around 3:4 PM [sic], then again at 5:45 PM. They called the supervisor. Two (2) all calls were done and a Code White. They documented they had not seen Resident #2 during the shift. At the time of the incident, they searched other floors, went to the first floor and spoke with security, involved floor certified nurse aides and supervisors. They notified Registered Nurse #26 and Nurse #40. During a telephone interview on 12/10/2025 at 2:02 PM, Licensed Practical Nurse #14 stated they recalled Resident #2 based on bringing clothes in for them. They came in a bit early for their shift on 02/24/2025 to bring the clothes to Resident #2. When they got there, the resident was not in the room. The roommate told them Resident #2 was visiting friends in the building. They returned to Resident #2's room later in the evening, and Resident #2 was still not back. They overhead paged and did a Code White. They searched down to the basement. They did not find Resident #2 and reported it to their supervisor. The 02/2025 Medication Administration Record documented the medications scheduled for 02/24/2025 at 5:00 PM to 10:00 PM and 7:00 PM to 11:00 PM were documented as Out of Building. Centers for Medicare and Medicaid Services documents in State Operations Manual Appendix PP, revision 232 issued 07/23/2025, that residents with a history of substance use disorder may be at increased risk for leaving the facility without notification and should be assessed for the risks and care plan interventions should be implemented to ensure the safety of all residents. Facilities are responsible for identifying and assessing a resident's risk for leaving the facility without notification to staff and developing interventions to address this risk. A situation in which a resident with decision-making capacity leaves the facility intentionally would generally not be considered an elopement unless the facility is unaware of the resident's departure and/or whereabouts. The 02/24/2025 at 11:16 PM Onondaga County 911 audio file, documented Resident #2 walked/snuck out of the building on foot sometime on the evening shift. The caller stated they were Registered Nurse #8. Resident #2 had mental or health concerns that included anxiety, depression, opioid dependence, and suicidal behaviors and ideations. They did not know when the resident left the building as they were third party to the information and just coming into work for the night shift. Based on (continued on next page)

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 02/03/2026
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	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	information gathered during the aforementioned telephone interview on 12/10/2025 at 2:02 PM with Licensed Practical Nurse #14, review of the aforementioned 02/24/2025 Incident Report - Employee Statement by Licensed Practical Nurse #14, and review of the aforementioned 02/24/2025 at 11:16 PM, Onondaga County 911 audio file, the Code [NAME] search did not locate Resident #2 within the facility, and the facility delayed calling emergency services. Onondaga County 911 was called five (5) hours and 31 minutes after Code [NAME] was initiated. During this time, the facility did not know of Resident #2's whereabouts. The 02/24/2025 at 11:21 PM, Onondaga Sheriff's Report, documented there was a missing person investigation that was later amended to a status check. They spoke with Licensed Practical Nurse #25 who stated they were the nursing supervisor, and they were made aware that Resident #2 was missing from [the facility]. Resident #2 had been missing since the 02/24/2025 evening check. The resident had a visitor around 11:00 AM that day and had mentioned they wanted to go back to their apartment. They stated Resident #2 was free to leave when they pleased. Although they were free to come and go, Resident #2 had never left the facility. Resident #2 was contacted by Police via telephone and would not provide their location but stated they would return to the facility on [DATE]. Day After Elopement, 02/25/2025: The 02/25/2025 at 5:41 AM progress note by Registered Nurse #8 documented Police were called to complete a wellness check and found Resident #2 at their home. It documented Police stated Resident #2 was an adult, was not a missing person, and they could make their own decisions. It documented Resident #2 decided not to return to the facility. During an interview on 12/22/2025 at 1:32 PM, Resident #2 stated the facility contacted them a day or so after they left (making it on/about 02/25/2025) and had a staff member meet them at Friend #28's house. Resident #2 stated they did not know they signed an Against Medical Advice document and were instead told they had to sign the papers the staff member brought. Resident #2 further stated the documents were not explained to Resident #2. The facility document Discharge Against Medical Advice documented Resident #2's name, dated 02/24/2025 at 2:30 PM. The document was signed by Resident #2, witnessed by Director of Social Work #17, and dated 02/25/2025. The discharge location was Friend #28's house with contact information. The reason for leaving Against Medical Advice was documented as resident did not want to stay at [Facility]. The 02/25/2025 at 02:25 PM progress note by Director of Social Work #17 documented they went to meet with the resident on this date to complete Against Medical Advice paperwork. The resident was able to sign paperwork on this date. Director of Social Work #17 asked the resident if they had any questions or concerns at this time which they did not. Resident had information to call the facility if needed and access to local hospital information. [Adult Protective Services] call was made. Director of Social Work #17 would continue to follow. There was no documented evidence that Resident #2 was counseled regarding the possible complications of the discharge intentions such as threat to physical and/or social well-being, or the need to make immediate arrangements for necessary medication or equipment when leaving the facility against medical advice. There was no documented evidence a physician was made aware that Resident #2 left the facility Against Medical Advice. Review of Residents Leaving [Facility] sign out sheet, dated 02/08/2025 to 02/28/2025, did not have documented evidence that Resident #2 signed out against medical advice, out on pass, or discharged . Record review revealed the facility informed Police that Resident #2 was free to leave despite no documentation of discharge, counseling, or physician notification. Interviews:During an interview on 12/16/2025 at 1:37 PM, Nurse Practitioner #37 stated Resident #2 was previously on their service, but the last note they wrote for them was on 02/24/2025. They stated they believed the resident was transferred to another unit, because they were still in the provider system, but not on their service. Resident #2 did not have the best decision-making skills. Based on the substance use disorder and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	behaviors, Resident #2 was at risk for leaving the facility. They should not be alone. Resident #2 would have been safe in terms of mobility, as they got around with their wheelchair. They would expect to be notified if a resident left against medical advice, and they were not notified. They would have to put in a discharge note and discharge the resident from the system. Resident #2 was still in the provider system and not a discharged resident. Nurse Practitioner #37 stated they would expect to be notified if a resident eloped from the facility, and they were not notified that Resident #2 left the facility in any way. Nurse Practitioner #37 stated they received notifications from the facility Monday through Friday at any time of day or night, but there was a weekend on call team also. During an interview on 12/16/2025 at 12:44 PM, Director of Social Work #17 stated they did not recall Resident #2, and Social Worker #29 was assigned to that resident. They did not recall any information that was not documented in the electronic medical record. They vaguely recalled going to Friend #28's house, meeting Resident #2 on the porch, and it being cold. Director of Social Work #17 could not recall why the documentation was dated 02/25/2025, why they went to the resident after they left on 02/24/2025. They stated there was a need to get the paperwork done, and they did what they had to do to get it done. Director of Social Work #17 stated once a resident says they want to leave against medical advice, there would be an interdisciplinary team discussion. Director of Social Work #17 further stated the team would need to figure out why the resident wanted to leave, and the facility should know when a resident leaves. During an interview on 12/09/2025 at 11:52 AM, Social Worker #29 stated there was nothing in the medical record to know what happened with Resident #2. They stated that they would have expected a note in the electronic medical record that documented the resident physically left with whomever and when they left. Resident #2 was at high risk, and of serious concern if they just left. They were homeless and had substance use disorder. During an interview on 12/09/2025 at 12:10 PM, Licensed Practical Nurse #31 stated that if the resident discharged against medical advice, physician orders would be discontinued. During an interview on 12/10/2025 at 3:21 PM, Security Guard #38 stated if a resident came to the desk trying to leave and asking to leave against medical advice, they would call the nursing supervisor to help with the resident. During a telephone interview on 12/16/2025 at 11:53 AM, Registered Nurse #12 stated the 2:00 PM administration time listed on the 02/24/2025 Medication Administration Record was the scheduled time of the medication. They had an hour before and an hour after that time to administer the medication. They did not recall a resident requesting to leave against medical advice or leaving the facility during their shift; and that was something they would have recalled. They further stated a resident with suicidal ideations and substance use disorder would not be someone that would be able to leave the building alone and would be a resident who would need continuous care and observation. During a telephone interview on 12/31/2025 at 01:31 PM, Onondaga County Sheriff Deputy #36 stated they went to the facility on the evening of 02/24/2025 for a missing resident. They went to Resident #2's room. Resident #2 left behind their wallet and identification. Deputy #36 stated they worked on the case for most of the night and made contact via telephone with Resident #2 between 3:00 and 4:00 AM on 02/25/2025. Resident #2 stated they were at a friend's house, but did not provide the actual location. Sheriff Deputy #36 reminded Resident #2 their wallet and identification were at the facility. Resident #2 stated they would return to the facility to collect their belongings. During a telephone interview on 12/16/2025 at 3:52 PM, Registered Nurse #8 stated Resident #2 was supposed to be in the facility when they got to work on 02/24/2025, but were not there. They contacted Director of Nursing #1, who told them to call emergency services for a wellness check. Registered Nurse #8 stated they thought Resident #2 was out on pass. They thought the resident left the facility with someone. Registered Nurse #8 further (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated they got information about the resident by reading the 24-hour report in the electronic medical record. They could not recall who notified them that the resident was not in the building. Registered Nurse #8 stated Police came to the facility, informed them the resident went out, did not return and they were concerned about the resident's safety. During an interview on 12/10/2025 at 12:06 PM, Director of Nursing #2 stated Resident #2 was discharged from the system on 02/24/2025 at 2:10 PM. They stated Resident #2 departed the facility with a friend that did not enter the building to check in. They did not know how they left. The time and date that a resident is discharged from the system indicated the resident was no longer in the building. The discharge time was determined by Assistant Administrator #1 and then, by reviewing the camera footage. Director of Nursing #2 stated Resident #2 independently moved around in the building. Director of Nursing #2 further stated the elopement assessment was done on admission, and the information was obtained on a nurse-to-nurse report, which might not be how the resident actually moved. The assessments were done quarterly. Director of Nursing #2 stated an assessment would not be completed for elopement once a resident was identified as being not mobile. Director of Nursing #2 stated if Resident #2's assessment information was carried over from the against medical advice assessment to the elopement assessment, Resident #2 probably would have triggered as an elopement risk. Director of Nursing #2 stated they did not know what time Resident #2 signed the against medical advice paperwork. Director of Nursing #2 stated the facility would complete follow up calls on residents that leave against medical advice to make sure the residents were safe. Director of Nursing #2 stated Resident #2 independently walked out of the building and was cognitively intact. Director of Nursing #2 further stated the facility made sure Resident #2 was safe at home at 11:00 PM on 02/24/2025. They stated Resident #2 did not leave undetected on 02/24/2025, that the front desk watched them leave but could not provide the exact time. Director of Nursing #2 stated they thought the resident departed out of the front door with the overhang but could not recall for sure. They stated they could not make someone sign out against medical advice if they did not want to. Director of Nursing #2 stated, Resident #2 was able to walk out the front door without their oxygen without concern. During an interview on 12/10/2025 at 3:11 PM, Administrator #1 stated they were not involved in Resident #2's discharge. Administrator #1 stated Resident #2's discharge was investigated by the facility, and that they would have to review the investigation to know the outcome. Administrator #1 stated Resident #2 was not an elopement risk but was at risk for leaving against medical advice. Administrator #1 stated staff could document on a resident at any time, such as if a resident was seen while in the building, staff could document after the fact. Administrator #1 stated it would be appropriate as documentation was just the vehicle. The facility was notified of the Immediate Jeopardy on 12/18/2025 at 3:19 PM, signed by Administrator #1 at 3:45 PM. Record review of the Facility Immediacy Removal Plan, version 01, submitted on 12/18/2025 at 4:24 PM revealed the facility's plan to remove the immediacy relied on already-completed risk assessments for elopements based on Minimum Data Set information that could be up to three (3) months old. There was no documented evidence that the facility would review current data points based on current resident conditions. Record review of the Facility Immediacy Removal Plan, version 02, submitted on 12/18/2025 at 6:30 PM revealed the facility did not specify what would happen next procedurally when a resident could not be located after calling a Code White. Additionally, the facility's plan to remove the immediacy relied on only elopement risk assessments. There was no documented evidence that other risk factors such as against medical advice risk assessments would be considered. The Facility Immediacy Removal Plan did not address how adequate supervision would be accurately determined for all residents in the facility, to then determine the subset of those residents at risk for elopement or at (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	risk for leaving the facility against medical advice, including cognitively intact residents with substance use disorders. During an interview on 12/18/2025 at 7:19 PM, Administrator #1 reviewed what was meant by Against Medical Advice, what the Elopement and Against Medical Advice risk assessments for Resident #2 were documented as. Administrator #1 reviewed that Resident #2's elopement risk score was documented as zero (0), requiring no care plan interventions, and that the Facility Immediacy Removal Plan only described elopement. When asked where a section of proposed immediacy removal plan that addressed how the facility would ensure adequate supervision for all residents, Administrator #1 stated they were only looking at it from the elopement perspective. Administrator #1 stated they would add a new line about a resident change of condition that would prompt a new Against Medical Advice and Elopement risk assessments. Administrator #1 stated law enforcement would be promptly called when a resident could not be found after issuing a Code White, that the policy would be revised, and all staff would be educated on the change. Facility Immediacy Removal Plan, version 03, submitted on 12/18/2025 at 7:54 PM was approved. The Immediate Jeopardy was lifted effective 12/19/2025. The facility's immediacy removal actions included the following:All residents in the facility had their elopement risk assessment completed within three (3) months in accordance with the Minimum Data Set and had interventions in place in accordance with the assessed risk.All residents assessed as an elopement risk that triggered the requirement for use of a Wanderguard bracelets had their bracelet in place. Residents with Wanderguard bracelets were placed on the Adventure Club list, which contains their picture indicating their elopement risk. This was within the electronic medical records and available to staff. If the resident required 1:1 supervision, that supervision was provided (two (2) residents) identified.Exit doors were inspected, locked, and alarmed. Their functionality was confirmed

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during the survey, the facility failed to ensure that it provided respiratory care consistent with professional standards of practice and the comprehensive person-centered care plan for one (1) (Resident #11) of three (3) residents reviewed. Specifically, the facility did not ensure Resident #11 was administered four (4) liters of oxygen as prescribed, when assessed by the Respiratory Therapist for shortness of breath during the evening shift on 11/25/2025. This is evidenced by: Cross-referenced to F580: Notification of Changes (Injury/Decline/Room, Etc.) Resident #11:Resident #11 was admitted to the facility on [DATE] with diagnoses of respiratory failure (condition where there's not enough oxygen or too much carbon dioxide in your body), unspecified whether with hypoxia (level of oxygen in the blood becomes dangerously low) or hypercapnia (level of carbon dioxide become dangerously high), obstructive sleep apnea (breathing is interrupted by the airway blocking the flow of air), and hypertension (high blood pressure). The Minimum Data Set (a resident assessment tool) dated 10/21/2025 documented resident was cognitively intact. The resident was able to make themselves understood and they understood others. The facility policy and procedure titled Oxygen Administration revised June 2025, documented the purpose of the procedure was to provide guidelines for safe oxygen administration. The first step of the procedure was to verify the physician order. The flow of the oxygen was to be set as prescribed by the physician. The care plan for Risk for Compromised Respiratory Status, revised 11/06/2025, documented obstructive sleep apnea, other pulmonary embolism without acute Cor Pulmonale (blood clot in the artery in the lungs without severe right-sided heart strain), not using continuous positive airway pressure machine to treat sleep apnea (CPAP). Goal: resident would have no untreated signs or symptoms of respiratory distress. Interventions: monitor resident's respiratory status: anxiety, restlessness, increased confusion, shortness of breath, dyspnea, lethargy (unusual decrease in consciousness), decreased activity, change in sputum production or change in color, character of sputum; monitor breath sounds, monitor activity tolerance, pace and space activities, provide restful calm environment, monitor vital signs, oxygen per physician order, consult with Respiratory Therapist as needed. The physician order dated 11/18/2024 for Oxygen Therapy Order, documented four (4) liters via nasal cannula, every day, every shift. The Treatment Administration Record dated November 2025, documented Oxygen Therapy, four (4) liters/minute, every day, every shift. Order start dated 11/18/2024. The Respiratory Progress Note dated 11/25/2025 at 6:38 PM by Respiratory Therapist #6 documented Resident #11 was assessed in their room during dinner in response to a nursing report of intermittent shortness of breath. The resident was alert, oriented, and in no apparent distress at the time of the assessment. Respirations were even and unlabored. Educated the resident on deep breathing techniques, including slow diaphragmatic breathing, paced inhalation and exhalation, and pursed lip breathing to promote improved lung expansion and assist in managing symptoms during episodes. Encouraged resident to practice these exercises daily and to notify staff promptly if symptoms increased in frequency or severity. Resident verbalized understanding and was receptive to education. Oxygen saturation level was 92% on three (3) liters. Lung sounds clear bilaterally. During an interview on 12/04/2025 at 11:24 AM, Health Care Proxy #11 stated they and the resident's granddaughter visited Resident #11 on 11/25/2025. At 2:50 PM, Resident #11 said they were having trouble with their breathing. They took the nasal cannula off the resident and said no air was coming out. They checked the oxygen concentrator and said it was set at three (3) or four (4) liters and was not working. Health Care Proxy #11 then turned the knob on the oxygen concentrator to increase the rate and the floating ball did not move. Health Care Proxy #11 left the room and asked a nurse (unknown) if (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they could help with the oxygen. They were told they could not help, and an order was placed for a Respiratory Therapy consult. No one came into the room, and Health Care Proxy #11 said they left the facility at 3:45 PM to get a pizza, while the granddaughter stayed with the resident. Health Care Proxy #11 stated that while they were gone, the granddaughter saw a portable oxygen tank in the room and asked staff (unknown) to help and was told they could not. The granddaughter then connected the nasal cannula to the portable tank. Health Care Proxy #11 did not know what the oxygen on the portable tank was set at. During an interview on 12/09/2025 at 4:37 PM, Respiratory Therapist #6 stated Licensed Practical Nurse #80 called them on 11/25/2025, and said the resident was short of breath. Respiratory Therapist #6 went to the resident's room (time unknown) found the resident eating pizza and was halfway through it. The resident was not in any distress. Resident #11 was connected to the portable oxygen tank that was set at three (3) liters. The resident's oxygen saturation level was 92% and they switched them over to the oxygen concentrator at three (3) liters. Respiratory Therapist #6 was not aware the resident was ordered to have four (4) liters oxygen. They stated they usually checked the oxygen order but did not because they recalled the resident being on three (3) liters at some point during their stay. During an interview on 12/11/2025 at 12:35 PM, Director of Nursing #1 stated they reviewed Resident #11's chart after they left the facility. They said the granddaughter was concerned about the resident on 11/25/2025 and wanted Respiratory Therapy to check them. After the nurse checked the resident, they had Respiratory Therapist #6 see the resident. Respiratory Therapist #6 saw the resident on 11/25/2025 and the resident was eating pizza. Director of Nursing #1 reviewed the Respiratory Therapist's note about the resident being on three (3) liters and the physician order for oxygen and stated it was for four (4) liters as of 11/18/2024. 10 New York Codes, Rules, and Regulations 415.12(k)(6)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during a survey, the facility failed to ensure it maintained medical records in accordance with accepted professional standards and practices, and that medical records on each resident were complete, accurately documented, readily accessible, and systematically organized for one (1) (Resident #11) of three (3) residents reviewed. Specifically, there was no documentation in the medical record of [a.] an assessment of Resident #11 by Registered Nurse #8 when the resident had respiratory and mental status changes on 11/26/2025, [b.] the resident's response to oxygen treatment provided by Registered Nurse #8 and Licensed Practical Nurse #4 on 11/26/2025, and [c.] the resident's vital signs (heart rate, blood pressure, respiratory rate, and temperature) on 11/26/2025. This is evidenced by: Cross-referenced to F580: Notification of Changes (Injury/Decline/Room, Etc.)Resident #11:Resident #11 was admitted to the facility on [DATE] with diagnoses of respiratory failure (condition where there's not enough oxygen or too much carbon dioxide in your body) unspecified whether with hypoxia (level of oxygen in the blood becomes dangerously low) or hypercapnia (level of carbon dioxide become dangerously high), obstructive sleep apnea (breathing is interrupted by the airway blocking the flow of air), and hypertension (high blood pressure). The Minimum Data Set (a resident assessment tool) dated 10/21/2025 documented the resident was cognitively intact. The resident was able to make themselves understood and they understood others. The facility policy and procedure titled Change in Resident Condition reviewed 05/2025, documented the charge nurse would record in the resident's medical record information relative to changes in the resident's medical/mental condition or status, initiating the SBAR (situation, background, assessment, recommendation) (a communication tool used primarily in healthcare to provide clear, concise, and critical information quickly, especially during urgent situations). The policy documented the Registered Nurse would complete an assessment of the resident, documenting on the SBAR. The facility policy and procedure titled Resident Hospital Transfer reviewed 06/2019, documented the Registered Nurse was responsible for the resident assessment in the event of an acute medical crisis or change in condition. The transferring Registered Nurse would call the hospital and give a verbal report to the Emergency Department Charge Nurse and would complete a nursing progress note that included all steps in the procedure, time of transfer, who transported the resident, and that the Emergency Department charge nurse was given report. The care plan for Risk for Compromised Respiratory Status, revised 11/06/2025, documented obstructive sleep apnea, other pulmonary embolism without acute cor pulmonale (blood clot in the artery in the lungs without severe right-sided heart strain), not using continuous positive airway pressure (CPAP) (machine to treat sleep apnea). Goal: resident would have no untreated signs or symptoms of respiratory distress. Interventions: monitor resident's respiratory status: anxiety, restlessness, increased confusion, shortness of breath, dyspnea, lethargy (unusual decrease in consciousness), decreased activity, change in sputum production or change in color, character of sputum; monitor breath sounds, monitor activity tolerance, pace and space activities, provide restful calm environment, monitor vital signs, oxygen per physician order, consult with Respiratory Therapist as needed. The Nursing Progress Note dated 11/26/2025 at 7:06 AM by Licensed Practical Nurse #4 documented at approximately 1:00 AM, Resident #11 was observed to be resting comfortably with no signs of acute distress. Through the night, the resident remained stable and responsive. At approximately 5:00 AM, Resident #11 was found to have labored respirations and appeared minimally responsive to verbal stimuli. Oxygen saturation level was 40 percent on four (4) liters nasal cannula. Supervisor [Registered Nurse #8] was immediately notified and came to assess at bedside, and (continued on next page)

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 02/03/2026
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.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they changed the nasal cannula to an oxygen mask. Oxygen saturation levels were checked again using three (3) separate oximeters (a non-invasive device clipped onto a finger that measures oxygen levels) simultaneously to verify accuracy. The readings obtained were 42 percent, 43 percent, and 26 percent with increased labored breathing. Supervisor [Registered Nurse #8] again updated with recommendation to send to Emergency Department due to the resident's worsening condition. Oxygen therapy was escalated to ten (10) liters via non-rebreather mask using the portable oxygen tank. Upon Emergency Medical Services arrival, Resident #11 became unresponsive and was transported to the hospital. There was no documented evidence of the resident's vital signs (heart rate, blood pressure, respiratory rate, and temperature) on 11/26/2025. There was no documented evidence of an assessment of the resident by Registered Nurse #8 when the resident had respiratory and mental status changes on 11/26/2025. The Nursing Progress Note dated 11/26/2025 at 5:57 AM by Registered Nurse #8 was blank. There was no documented evidence of the resident's response to oxygen treatment provided by Registered Nurse #8 and Licensed Practical Nurse #4 on 11/26/2025. The Nursing Progress Note dated 11/26/2025 at 6:59 AM by Registered Nurse #7 documented, Registered Nurse #7 received report from the licensed practical nurse. Patient's oxygen saturation 42 percent, 43 percent, unresponsive, vital signs unable to be taken. Registered Nurse #8 assessed the patient per Licensed Practical Nurse [#4]. Sent out to hospital. Registered Nurse #7 notified the Nurse Practitioner [#44]. During an interview on 12/04/2025 at 3:56 PM, Licensed Practical Nurse #4 stated that between 4:30 AM and 5:00 AM, Certified Nurse Aide #15 came to them running and told them Resident #11 was not breathing right and was labored. They went right to the resident and the resident was minimally verbally responsive. The resident could say their own name and was labored in their breathing. They stated the resident's oxygen level was 40 percent. Licensed Practical Nurse #4 then notified the Registered Nurse #8, who came to the resident's room and told them to get an oxygen face mask. They stated they checked the blood pressure, and it was 132/74 or 76, respiratory rate was 20 to 22 breaths per minute, labored and was 24 when Emergency Medical Services arrived, and they wrote them on a cheat sheet. During an interview on 12/9/2025 at 3:51 PM, Registered Nurse #8 stated they were the nursing supervisor during the night shift on 11/25/2025, from 11:00 PM to 7:00 AM. They did not recall who Resident #11 was. They recalled Resident #11's oxygen saturation level was 88 percent, could not get the resident up to 90 percent, and ended up sending the resident out to the hospital. Licensed Practical Nurse #4 switched the resident to an oxygen mask that could be used for up to ten (10) liters of oxygen. They did not know how many liters Licensed Practical Nurse #4 administered and stated they were sure the resident was on the highest setting. They stated the resident dipped down to 45 percent and they called 911They stated they forgot to a write a note. During an interview on 12/10/2025 at 2:30 PM, Registered Nurse #7 stated the only reason they wrote the note about Resident #11 on 11/26/2025 was because Registered Nurse #8 left the building on 11/26/2025 and there was no communication from Registered Nurse #8. They said they saw Emergency Medical Services transporting the resident out of the building. Registered Nurse #7 talked to Licensed Practical Nurse #4 and told them to write a note. During an interview on 12/11/2025 at 12:35 PM, Director of Nursing #1 stated they reviewed Resident #11's chart after they left the facility. They would expect registered nurses to write assessment notes and stated Registered Nurse #8 attempted to write a note on 11/26/2025, but it was not saved in the computer system. 10 New York Codes, Rules, and Regulations 415.22(a)(1-4)

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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

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a Compliance and Ethics Program. Based on observations, record review, and interviews during the survey, the facility failed to develop, implement, and maintain an effective compliance and ethics program that is likely to be effective in preventing and detecting criminal, civil, and administrative violations and promoting quality of care. Specifically, the facility failed to create and promote a program contact to which individuals may report suspected violations, as well as an alternate method of reporting suspected violations anonymously without fear of retribution. Findings include:The undated and unsigned facility policy Code of Conduct documented all affected individuals were to abide by standards outlined in the Code of Conduct and to conduct all business in a manner consistent with the facility policies set forth in the Code of Conduct and Compliance documents. Illegal acts or unethical conduct was not acceptable, staff were to perform duties with honesty and integrity, and supervisors and managers were responsible for ensuring that the affected individuals within their supervision were acting ethically and within compliance of all rules. All affected individuals were expected to report any potential concern in good faith and to assist as necessary with any investigation.The undated and unsigned facility policy Non-retaliation and Non-retribution documented its purpose as: protection of any affected individuals who, in good faith, participates in investigations or reports alleged violations of Federal and State laws, rules or regulations; or files a report in good faith of suspected fraud, waste, abuse or unethical behavior; to encourage reporting in good faith of misconduct or suspected violations of the Code of Conduct; Federal and State laws, rules and regulations without fear and promote compliance with participating in the Compliance Program. In the Statement of Policy section the Non-retaliation and Non-retribution policy defines Retaliation and retribution as: any adverse action taken, or threatened against another Affected Individual because they have, in good faith, reported an allegation concerning fraud, waste, abuse or a violation of Federal or State laws, rules or regulations or because they have participated in any manner with an investigation regarding an allegation and it created a hostile, threatening, or uncomfortable environment as a result of the reported complaint. Examples of retaliation or retribution included in the policy are termination or illegal retraction of benefits, suspension, reduction of compensation, demotion, failure to consider or promotion, harassment, or defamation of character created an environment of fear was harmful and strictly prohibited. The policy also includes various reporting channels including a hotline number that could be used anonymously and confidentially.The facility policy Prevention of Abuse, Neglect, Involuntary Seclusion and Misappropriation of Property last reviewed 05/2025, documented all employees shall receive information on how and to whom they report concerns, incidents, and grievances without fear of retribution.Due to the critical content of the interviews and evidence provided during the survey with repeated verbalization of staff concerns related to potential retaliation by the facility, all staff will be identified as Staff unless the position title is critical to deficiency understanding.This survey investigated a confidential and anonymous complaint with allegations related to unethical standards of nursing and administrative practices regarding documentation related to a resident's elopement from the facility. Review of complaints with allegations of retaliation:Staff [D] stated they could try to report violations to the Director of Nursing #1, but it was a long shot. It would depend on what they were reporting and who they were reporting it to, if it would be heard. The unit manager conveyed to staff members that their title was more important than the staff reporting to them. Staff [A] stated they did not think they could report compliance matters without retaliation. They would be worried they would not get vacation, offered overtime, or that they would not be needed the next week. They knew that after they left the interview (with State Surveyors), Director of Nursing #1 would call to see what was discussed as Director of (continued on next page)

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Nursing #1 contacted them and asked what was discussed after a previous interview with the State Surveyors. Staff [B] stated that reporting anything anonymously was a joke. There was no way to report something anonymously, someone would find out and someone would report what they did. They were not confident they could report anything without fear of retaliation. They would only feel comfortable reporting to their immediate manager, but above them, they did not trust reporting anything. Staff [C] stated that some of the staff would retaliate against them. They were afraid someone would slash their tires. They had been threatened that someone would beat them up. They heard someone in the breakroom threaten to have their grown son beat someone. Surveyor interactions with facility Administration during the survey process: During an interview on 12/17/2025 at 2:36 PM, Director of Nursing #1 asked State surveyors how much longer the State was going to be in the facility as they stress out the facility staff, and Director of Nursing #1 stated they would hate for the facility staff to get punchy with them. During an observation and interview on 12/18/2025 at 3:19 PM with Administrator #1, Assistant Administrator #1 and Director of Nursing #1, Administrator #1 began to refute the allegations and demanded the surveyor explain where they got their information, the appropriateness of questions asked to the staff, and the appropriateness of the survey process and timeline of the citation related to the recent recertification survey. Assistant Administrator #1 wanted an explanation of what questions were asked of the staff, who was interviewed, and what the staff members responses were. Director of Nursing #1 stated the facility had a similar tag thrown away in the Independent Dispute Resolution process before because the surveyor did not ask the correct questions during the interview process, and they would just do it again with this citation. All three (3) members of the administrative team spoke in elevated voices. Their bodies were in a leaned forward position. During several moments of the interaction, all three (3) members had their hands clenched in a fist on the table between them and the Surveyors. They asked multiple times who decided that the Immediate Jeopardy was issued. State Surveyors stated that the decision to issue the Immediate Jeopardy was from their supervisors. They then demanded the State Surveyors state what data was provided to the supervisors of the investigation. The Surveyors provided phone numbers to their supervisors and told them they could reach out with additional information. Administrator #1 asked what suggestions Surveyors had to lift the immediacy and what was needed that they did not already have in place. State Surveyor stated that if safeguards were in place, to outline that information. Administrator #1 stated they would not sign the Immediate Jeopardy template until they spoke with the Surveyor's Supervisor. Throughout the course of the interview, the administrative team increased the volume of their voices, postured leaning forward, and talked over Surveyors. During an observation and interview on 12/18/2025 at 4:15 PM, the Surveyors let Administrator #1 know they were leaving the building and the process for the next steps in their Immediate Jeopardy including the review of the removal plan being completed by the survey supervisors. Administrator #1 followed the Surveyors into the Administrative Lobby and stated they were just issued an Immediate Jeopardy and the Surveyors could not leave. The process for next steps was explained again by State Surveyors and Administrator #1 again asked how it was that the Surveyors could leave. It was explained that tensions were high, and the supervisors thought it best that the Surveyors leave. Administrator #1 stated, Of course tensions [were] high, they [were] in Immediate Jeopardy. 10 New York Codes, Rules, and Regulations S 415.26 (c)