

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  03/11/2026
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 0684  Level of Harm - Actual harm  Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.  **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during a survey, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for one (1) of one (1) resident (Resident #1) reviewed. Specifically, from 12/15/2025-01/30/2026 Resident #1 had acute medical complaints including urinary symptoms. Urinalysis reports on 12/19/2025 and 01/01/2026 were not adequately addressed by nursing and medical; the resident was treated multiple times with a cephalosporin (antibiotic) without obtaining a urine culture and sensitivity; and a urology consult was not reviewed. The resident continued with frequent complaints of not feeling well and was hospitalized on [DATE] and admitted to the intensive care unit for urosepsis (life threatening response to a urinary tract infection) and metabolic acidosis (acid build up in the blood). This resulted in actual harm to Resident #1 that was not Immediate Jeopardy. Findings include: The facility policy Physician Visits, revised 05/2025, documented the attending physician performed relevant tasks at the time of each visit that included a review of the resident's total program of care and appropriate documentation. The undated facility policy [Laboratory] Diagnostics Results and Reporting Overview, documented the laboratory results were seamlessly integrated with all other relevant clinical information in a patient's electronic medical record, making it easier to provide patients with the best possible care. The provider or authorized representative had the responsibility of interpreting the result in the context of the patient's clinical condition and taking appropriate action. The facility policy Outside Consults Policy, revised 04/2025, documented the Unit Manager/ Charge Nurse documented confirmation in the electronic medical record of follow up appointments and any recommendations. The Unit Manager reviewed recommendations with the resident's provider. Resident #1 had diagnoses including chronic kidney disease, diabetes, and a history of urinary tract infections. The 11/27/2025 Minimum Data Set assessment (a resident assessment tool) documented the resident was cognitively intact, was independent with activities of daily living, and was always continent of urine. The 12/15/2025 Registered Nurse Unit Manager #6 progress note documented the resident had acute dysuria (painful urination) and new/increased incontinence, urgency, and frequency. An order for urinalysis and urine culture was obtained from Nurse Practitioner #5. The 12/15/2025 Nurse Practitioner #5 progress note documented the resident was seen per nursing request for follow up of dysuria. The resident reported increased frequency of urination as well as some incontinence due to urgency. The plan was to have nursing send a urine for evaluation of a possible urinary tract infection. The 12/18/2025 Nurse Practitioner #5 progress note documented the resident was seen for follow up of urine results. Nursing sent a urine sample but for some reason the laboratory did not run it. The resident reported their symptoms improved a bit so for now they would hold off on sending another sample and continue to monitor. The 12/19/2025 urinalysis laboratory report documented a urine specimen was collected 12/17/2025 at 1:15 PM, received by the lab on 12/19/2025 at 2:04 AM, and reported to the facility on [DATE] at 11:48 AM. The test was not performed because a suitable specimen was not received. Please resubmit order with yellow top urinalysis transport tube. The 12/19/2025 Registered Nurse #15 progress note documented the resident's temperature was 101.9 degrees Fahrenheit. There was no documented evidence of the (continued on next page)		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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