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	05/13/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review conducted during survey, the facility failed to maintain a clean and homelike environment. Specifically, on 05/07/2026, Resident #118's recessed light had no light bulb. On 05/05/2026, Resident #27's room walls were dirty, and Resident #126's overbed table had a full, odorous urinal on it. Observations on 05/05/2026 noted sticky floors including Resident #118's room door and floor, the 7th floor nurses station floor, and the 3rd floor common area/core floor. Findings include:Facility housekeeping in-service training, revised 03/2016, documented resident rooms were cleaned to ensure optimum levels of cleanliness and sanitation, prohibit the spread of infection and bacteria and maintain the outward appearance of the facility. Steps in the daily cleaning of a resident room included emptying wastebaskets, cleaning and dusting all horizontal surfaces, cleaning and dusting all vertical surfaces, dust mop the floor, and damp mop the floor. It further documented that the average time for a routine resident room cleaning was 14 minutes. During observations on 05/05/2025 between 6:32 AM and 11:58 AM, the following locations were noted with sticky floors:Hallway outside of Rooms #301, #322, and #640.3rd floor main common/dining room (called Core).room [ROOM NUMBER].Resident #118's room and door.7th floor nurses' station. During an observation on 05/05/2026 at 9:11 AM, a full, odorous urinal was on Resident #126's overbed table. During a Resident Council interview on 05/06/2026 at 10:30 AM, 10 anonymous residents stated the facility was not clean. They stated some of the housekeepers would just change the garbage in their rooms but did not do any other cleaning. They stated the facility was trying to clean better in the Core and hallways, but not so much in the resident rooms. Resident #118:Resident #118 was admitted to the facility with diagnoses of unspecified anemia (low levels of healthy red blood cells and can cause tiredness, weakness, and shortness of breath), atrial fibrillation (irregular and often very rapid heart rhythm) and unspecified anxiety disorder (repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes (panic attacks), and other respiratory disorders that were not documented. The Minimum Data Set (a resident assessment tool) dated 02/26/2026, documented the resident was cognitively intact, was able to make themselves understood, and usually understood others. During an interview on 05/07/2026 at 10:32 AM, Resident #118 pointed to the recessed light in the ceiling near their wardrobe and stated they had not had light there since the light bulb was removed from the fixture and was put into the roommate's recessed light fixture. There was no light bulb in the light fixture. Resident #118 also stated there was a light bulb out in the bathroom over the sink and they did not have enough light in the room. During an observation on 05/07/2026 at 10:30 AM, one of two light bulbs above Resident #118's bathroom sink was not working, and the room was dimly lit. During an interview at this time, Resident #118 stated the maintenance department was aware and had not replaced the bulbs. During an interview on 05/12/2026 at 4:53 PM, Assistant Director of Nursing #2 stated Resident #118 had spoken to them about the lighting in the room and they thought the resident wanted the room [NAME]. They stated they tried their best to accommodate the resident and would put in a work order for maintenance. During an interview on 05/05/2026 at 9:25 AM, Housekeeper #1 stated they are responsible for daily (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cleaning of approximately 20 rooms, which included throwing away trash, cleaning the sink and toilet, refreshing toilet paper, dusting, sweeping and mopping the floors, and making sure the wet floor sign is present. Housekeeper #1 stated if there was a bowel movement in a resident room, the aide would pick it up and then Housekeeper #1 would disinfect and clean the surface with bleach. There are specific rooms that require additional cleaning, wiping down the walls, and removing more trash. During an interview on 05/12/2026 at 5:51 PM, Director of Plant and Operations #1 stated they oversaw security, maintenance, and plant operations for all mechanical aspects of the building systems. Director of Plant and Operations #1 stated maintenance department consists of 13 employees who work from a work order system and fix issues in resident rooms including replacing light bulbs. Any staff member can put a work order in. 10 New York Codes, Rules, and Regulations 415.14(h)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **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 comprehensive person-centered care plans were developed and implemented in accordance with professional standards of practice for two residents (Resident #118 and #248) out of three residents reviewed. Specifically, (a.) Resident #118 received medications for unspecified anemia, iron deficiency, and dry eye syndrome and a care plan was not developed and implemented for the diagnoses; and (b.) Resident #248 was involved in a resident-to-resident physical altercation on 01/20/2026 at 6:50 AM, and a comprehensive care plan for abuse was not developed and implemented. Additionally, Resident #248 had oral surgery on 01/21/2026 and a care plan was not developed and implemented. Findings include: Cross-referenced to F770: Laboratory Services The Policy and Procedure titled, Care Planning/Care Conference Policy, reviewed 02/19/2026, documented the facility utilized a person-centered approach to care planning. The policy ensured that each resident had a comprehensive person-centered care plan with individualized, measurable objectives and timeframes designed to meet the resident's medical, nursing, mental, and psychosocial needs. The comprehensive care plan must include the resident specific applicable services/interventions that were furnished to attain or maintain the residents' highest practicable physical, mental and psychosocial well-being. The care plan would be reviewed and revised as appropriate including any significant change in condition/status and change/update in resident needs, goals, and/or interventions. Each resident's comprehensive care plan would be prepared by the Interdisciplinary Team representing all appropriate health care professionals involved in the resident's care. Resident #118 Resident # 118 was admitted to the facility with diagnoses of unspecified anemia (low levels of healthy red blood cells and can cause tiredness, weakness, and shortness of breath), atrial fibrillation (irregular and often very rapid heart rhythm), and dry eye syndrome of bilateral lacrimal glands (insufficient watery tears are produced by the glands above each eye). The Minimum Data Set (a resident assessment tool) dated 02/26/2026, documented the resident was cognitively intact, was able to make themselves understood, and usually understood others. The resident was assessed to have an active diagnosis of anemia in the last seven days prior to the assessment. There was no documented evidence that a comprehensive person-centered care plan was developed for the diagnoses of anemia, iron deficiency, or dry eye syndrome of bilateral lacrimal glands. The Federally Mandated Visit dated 04/10/2026, by Nurse Practitioner #1, documented that they saw Resident #118 on 04/10/2026. The plan included iron deficiency anemia and documented to continue ferrous sulfate (used to treat/prevent iron deficiency anemia), dry eye and documented to continue artificial tears. Resident #248: Resident #248 was admitted to the facility with diagnoses of encounter for other orthopedic aftercare (fracture of right lower leg), urinary tract infection, and chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs). The Minimum Data Set, dated [DATE], documented that the resident was cognitively intact, was able to make themselves understood, and understood others. The Comprehensive Care Plan for Cognition, Psychosocial, Mood State and Behavior, revised on 02/15/2026, documented the resident had a negative mood state and could easily become agitated and anxious. This was due to their history of past trauma, including sexual assault in the community, and was easily startled. The resident had a tendency to confabulate stories against staff with multiple roommates. Approaches included for Social Work to remain available and reassure the resident they were safe. On 02/15/2026 at 9:33 PM, Resident #248 presented with interpersonal conflict related to shared living arrangements. The resident continued to have verbal disagreements with roommates and demonstrated difficulty interacting with staff at times. Episodes appeared to be related to heightened anxiety and poor tolerance of environmental stressors. The resident remained diagnosed with Post-Traumatic Stress Disorder (a mental health condition that was caused by an (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extremely stressful or terrifying event), which may contribute to increased reactivity and mistrust in social situations. The resident was assigned two staff members for care. The Resident/Visitor - Incident/Accident Report dated 01/20/2026 at 6:50 AM, documented an unobserved incident. Resident #248 called staff to the room by using the call bell. Resident #248 stated they were sleeping, and someone was touching their back. Resident #248 hit the person in the face, and it was their roommate. The Resident Statement by Resident #248 dated 01/20/2026, documented they hit their roommate in the face because they were startled awake by the roommate touching them on their buttocks. The untimed Nursing Progress Note dated 01/20/2026, by Registered Nurse #13, documented Resident #248 was sleeping in their bed and felt someone touching them on their back. The resident was startled and hit their roommate in the face. The roommate sustained no injuries. Resident #248 was very sorry for hitting their roommate. Registered Nurse #13 reassured Resident #248 that their roommate was not hurt. There was no documented evidence of updated interventions related to the resident-to-resident physical altercation on 01/20/2026 at 6:50 AM within the comprehensive person-centered care plan. The untimed Nursing Progress Note dated 01/21/2026, by Registered Nurse #3, documented Resident #248 returned from a dental procedure with new orders (not documented) that were reviewed with the Nurse Practitioner. Pain medication was given with positive effect. No active bleeding was noted. Soft foods were offered and received for dinner. No further issues were verbalized. Plan of care ongoing. The untimed Nursing Progress Note dated 01/22/2026, by Registered Nurse #3, documented Resident #248 was adjusting well status post dental surgery. Pain well controlled. No active bleeding or acute distress noted. Plan of care ongoing. There was no documented evidence a comprehensive person-centered care plan was developed and implemented for the oral surgery dated 01/21/2026. During an interview on 05/12/2026 at 4:53 PM, Assistant Director of Nursing #2 stated they were responsible for Resident #118's comprehensive care plan and stated there should have been a care plan for all diagnoses that were treated. During an interview on 05/13/2026 at 9:59 AM, Registered Nurse #3 stated they managed the 6th floor unit and were new to the facility. They stated they were responsible for care planning. They were not aware there was no care plan for the resident-to-resident physical altercation on 01/20/2026 and potential for abuse. They interviewed Resident #248, and the resident told them their roommate, who had dementia and wandered to the other side of the room, did not touch their anus. They were aware that Resident #248 had oral surgery on 01/21/2026. They were not sure if a care plan was developed and implemented. They stated they would take care of the care plans. During an interview on 05/13/2026 at 11:45 AM, Director of Nursing #1 stated there should be a care plan for every diagnosis. 10 New York Code of Rules and Regulations 415.11(c)(1)

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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 - 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 conducted during 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 of 60 residents reviewed. The facility failed to provide oversight, monitoring, and effective communication between staff and practitioners. Specifically, Resident #118 did not have a hematology consultation that was ordered and laboratory tests were completed 14 days after they were ordered. This resulted in actual physical harm for Resident #118 that was not Immediate Jeopardy. Findings include: The facility policy and procedure titled, Continuity of Care, revised 05/2025, documented quality of care was a fundamental principle that applied to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Nurses were expected to follow valid orders from physicians or other authorized healthcare providers. Hematology Consult Resident #118 was admitted to the facility with diagnoses of unspecified anemia (blood has insufficient red blood cells), atrial fibrillation (irregular heart rhythm), and unspecified anxiety disorder. The [DATE] Minimum Data Set (a resident assessment tool) documented the resident was cognitively intact, was able to make themselves understood, and usually understood others. The progress note dated [DATE] by Nurse Practitioner #1 documented the resident reported seeing a hematologist in the past for anemia. The plan was to add a hematology consult and requested the ward clerk get the resident an appointment for further follow up. On [DATE], the physician order documented hematology consultation for iron deficiency. There was no documented evidence that a hematology appointment was made for the resident. Review of medical visit progress notes by Nurse Practitioner #1 documented: -On [DATE], plan included iron deficiency anemia and documented follow up with hematology. -On [DATE], plan included iron deficiency anemia and documented follow up with hematology. -On [DATE], plan documented the resident had not followed up with hematology yet. -On [DATE], plan included iron deficiency anemia and documented still waiting for appointment with hematology. -On [DATE], plan documented the resident was previously followed as an outpatient by hematology/oncology and an appointment was requested. Nurse Practitioner #1 followed up with the ward clerk and apparently since the resident had not been seen at that practice for quite some time, they needed a new referral, and they were awaiting a new patient appointment. -On [DATE], Nurse Practitioner #1 reordered a hematology consultation for iron deficiency anemia. There was no documented evidence in the medical record regarding the status of the consultation. During an interview on [DATE] at 3:03 PM, Resident #118 stated they had a medical condition and required iron supplements and vitamin B12 injections. They said they had been to the hospital 13 times to figure out why they were losing blood and eventually discovered they were not making enough blood. There was no cancer. Resident #118 was hospitalized in [DATE]. Prior to this hospitalization, Resident #118 stated that it took four weeks for staff to do blood work when they complained of feeling weak. One night when they were feeling really weak they saw Assistant Director of Nursing #2 and told them they did not feel good. They tested their blood in the morning and were told they had to send them to the hospital. The resident stated, I was very sick. The resident was in the hospital for five days and received three units of blood. The resident stated, I could have died. During an interview on [DATE] at 10:32 AM, Family Member #1 stated they were praying the facility was currently doing the bloodwork on time, which should be every two weeks because the resident had anemia and received iron. Prior to the resident's hospitalization on [DATE], they had spoken with Social Worker #1 and Assistant Director of Nursing #2 on separate occasions in the beginning of [DATE] about the bloodwork needing to be done for the resident's diagnosis of anemia and were told they would take care of it. Family Member #1 stated they were very concerned about (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	the resident getting proper care at the facility. During an interview on [DATE] at 5:18 PM, Nurse Practitioner #1 stated they were familiar with Resident #118. The resident had a diagnosis of anxiety and expressed their concerns daily. The resident first started talking about their anemia in February or [DATE]. They ordered a hematology consult after the resident told them they saw a hematologist for their anemia in the past. The ward clerk told them (date unknown) that the hematologist would not see the resident because they owed the provider money. Laboratory Orders The undated facility policy and procedure titled, Request for Diagnostic Services, documented all requests for diagnostic services must be ordered by the resident's attending physician. All orders for diagnostic services must be entered into the resident's medical record and signed by the attending physician. Orders for diagnostic services would be promptly carried out as instructed by the physician's order. Emergency requests must be labeled stat to assure prompt action was taken. The Medical Progress Note dated [DATE] by Nurse Practitioner #1, documented Resident #118 was seen on [DATE], and they would order laboratory tests to check their hemoglobin (a protein in the blood that carries oxygen) level. The Physician Orders report from [DATE] to [DATE], documented: On [DATE] at 1:56 PM, a one-time Laboratory Request Order for a complete blood count (blood test that measures the number and types of cells circulating in your blood) for diagnosis of unspecified anemia. On [DATE] at 3:52 PM, this order was discontinued and documented as the order having been replaced. On [DATE] at 3:52 PM, a one-time Laboratory Request Order for a complete blood count and magnesium level for diagnosis of unspecified anemia. On [DATE] at 7:51 AM, this order was discontinued and documented as the order having been replaced. On [DATE] at 7:51 AM a one-time Laboratory Request Order for a complete blood count and magnesium level for diagnosis of unspecified anemia. On [DATE] at 10:13 AM, the order was discontinued and documented as the order having been replaced. On [DATE] at 10:13 AM, a one-time Laboratory Request Order for a complete blood count and magnesium level for diagnosis of unspecified anemia. There was no documented evidence of laboratory test results for a complete blood count and magnesium level dated [DATE] or [DATE]. The [DATE] Nurse Practitioner #1 progress note documented they saw the resident for evaluation of their pain, chronic obstructive pulmonary disease and their routine 30-day facility follow-up. Diagnoses included iron deficiency anemia with a plan including continue ferrous sulfate (iron supplement) and waiting for appointment with hematology. There was no documentation in the note dated [DATE] by Nurse Practitioner #1 about the status of the laboratory tests for the complete blood count and magnesium. There were no nursing progress notes dated from [DATE] to [DATE]. There were no progress notes dated [DATE] to [DATE]. The progress note dated [DATE] by Nurse Practitioner #1, documented that they saw the resident on [DATE] at the request of nursing to follow-up on the resident's shortness of breath. The resident reported they had some increased shortness of breath with exertion. Plan documented they would have respiratory come and evaluate them. They discussed that the shortness of breath could also be due to other reasons as they did have quite a bit of anxiety. The laboratory results for Resident #118 dated [DATE] at 1:04 PM documented for the complete blood count: the white blood cell count was low, the red blood cell count was low, and hemoglobin was low. It further documented hemoglobin was at 4.6 g/dL, indicated it was a priority and was outside of the normal reference range of 11.7 - 15.5 g/dL. Additionally, hematocrit (measures how much of the blood consists of red blood cells) was low at 15.6 percent, outside of the normal reference range of 35.9 - 46.0 percent. The nursing progress note dated [DATE] at 1:52 PM by Assistant Director of Nursing #2 documented they received a call from the laboratory with critical lab values. Resident #118's hemoglobin level was critically low at 4.5, and white blood count was critically low at 2.2. Upon assessment the resident reported feeling fatigued and generally unwell. An order was obtained to send the resident to the hospital. Notified attending nurse practitioner of the results and received an order to send the resident out (to the hospital) for emergency transfusion. The hospital History and Physical dated [DATE] documented the resident reported a history of chronic anemia and noticed worsening shortness of breath with exertion for the last one to two weeks, suspected their anemia was worse, and requested (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	the provider repeat the laboratory work. Assessment and Plan included acute on chronic anemia (a sudden and rapid decrease in red blood cells) and a transfusion of red blood cells was in progress. The shortness of breath on exertion was likely secondary to symptomatic anemia (occurs when a drop in red blood cells or hemoglobin reduces oxygen delivery to the organs and causes tiredness, weakness, or shortness of breath). The Hospital Discharge summary dated [DATE], documented the resident had a history of chronic anemia requiring multiple transfusions of blood, vitamin B12 shots, and iron infusions in the past. The resident reported to the facility for approximately two weeks that they had been fatigued, experiencing weakness with some leg tenderness, which they recognized as signs that their blood was low. There was no laboratory work done at the facility until just prior to admission to the hospital on [DATE]. The resident was given two units of red blood cells in the Emergency Department and a repeat complete blood count showed correction of the hemoglobin to 7.6 and 23.8 for the hematocrit. The resident was admitted to the inpatient floors for monitoring of acute on chronic anemia. The nursing progress note dated [DATE] at 3:00 PM by Registered Nurse #10 documented the resident was readmitted to the facility from the hospital on [DATE], with diagnosis of pancytopenia (low levels of red and white blood cells and platelets (cells that clot blood). During an interview on [DATE] at 3:03 PM, Resident #118 stated they had a medical condition and required iron supplements and B12 injections. They said they had been to the hospital 13 times to figure out why they were losing blood and eventually discovered they were not making enough blood. Resident #118 was hospitalized in [DATE] for five days and received multiple units of blood. Prior to this hospitalization in [DATE], Resident #118 stated that it took them four weeks for staff to do blood work when they complained of feeling weak. The resident stated, I was very sick. I could have died. During an interview on [DATE] at 10:32 AM, Family Member #1 stated they were praying the facility was currently doing the resident's bloodwork on time, which should be every two weeks because the resident had anemia and received iron. Prior to the resident's hospitalization on [DATE], they spoke with the social worker and Assistant Director of Nursing #2 on separate occasions in the beginning of [DATE] about the bloodwork that needed to be done for the resident's diagnosis of anemia and they were told they would take care of it.ˆFamily Member #1 stated they were very concerned about the resident getting the proper care that they needed at the facility. During an interview on [DATE] at 4:53 PM, Assistant Director of Nursing #2 stated they managed the 5th floor unit. Nurse Practitioner #1 saw Resident #118 on [DATE]. Resident #118 had anemia and Nurse Practitioner #1 entered an order in the computer system for a laboratory test to check their hemoglobin levels. For reasons unknown, the phlebotomist (healthcare professional who draws blood and other specimens) did not come into the facility to draw the resident's blood (collect the specimen). There was supposed to be a follow up done to ensure laboratory tests were drawn but they were not made aware and therefore did not follow up. Assistant Director of Nursing #2 stated they were not made aware until it was far later than it should have been. On [DATE], they were notified by the laboratory that the resident's hemoglobin level was critically low. The resident was not feeling well and was sent to the hospital.ˆThey stated the first symptom they recalled the resident having was the resident wanting something for asthma and it did not occur to them that the resident was short of breath. That was a few days prior to [DATE]. Assistant Director of Nursing #2 thought it was respiratory related and did not follow up on it. They stated they did not make a connection with the shortness of breath to the anemia until they received the laboratory results on [DATE]. During an interview on [DATE] at 5:18 PM, Nurse Practitioner #1 stated they were extremely familiar with Resident #118. The resident had a diagnosis of anxiety and expressed their concerns daily. The resident first started talking about their anemia in February or [DATE].ˆThey saw the resident on [DATE] and ordered a laboratory test to check the status of the resident's chronic anemia. The specimen for the laboratory test was not drawn, and they did not know why. They explained the process for ordering a laboratory test. Nurse Practitioner #1 entered the order into the electronic medical record system and then the nurse or ward clerk had to enter the order into the laboratory computer system to alert them of the order. The nurse (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	or ward clerk would then print the laboratory requisition for the order(s) from the laboratory computer system and would put the requisition in a binder for the phlebotomist. The phlebotomist came into the facility on Monday, Wednesday, and Friday to collect specimens, or would come if something was ordered urgently. The phlebotomist was supposed to look in the binder for the requisition and then collect the specimen. They were not sure if the order they entered on [DATE] was entered into the laboratory computer system or if the phlebotomist missed the requisition for it. They reviewed the orders and stated it looked like they put the order in for the laboratory test a couple times and it finally got drawn on [DATE].ˆThey stated the ward clerk was responsible for ensuring a laboratory test was ordered in the laboratory computer system and then drawn.ˆThey did not know who provided oversight for the process of ordering laboratory tests. The resident was sent to the hospital on [DATE] and had blood transfusions.ˆ During an interview on [DATE] at 11:45 AM, Director of Nursing #1 stated if a provider placed an order for a laboratory test independent of the nurse manager, the manager would not know it was in the computer system and needed to be drawn. The laboratory obtained blood specimens on Monday, Wednesday, and Friday. If the test was ordered after 3:00 PM, the laboratory would not be alerted that a specimen needed to be drawn. The Director of Nursing #1 reviewed the orders and stated a complete blood count was ordered on [DATE] at 3:52 PM. This would have been too late to be drawn the next day, Friday. Nurse Practitioner #1 put in another order for a complete blood count on [DATE] at 7:51 AM, a Friday and again the specimen was not drawn because the phlebotomist was in and out of the building relatively quickly. They stated they had experienced issues with the laboratory and there were process improvement plans. If Assistant Director of Nursing #2 was not made aware of the need for the laboratory test, they would not know they had to follow up. During an interview on [DATE] at 12:03 PM, [NAME] Clerk #3 stated they were responsible for reviewing the electronic medical record for laboratory orders. The nurse practitioner entered the order in the electronic medical record system. They checked the system for orders, or the nurse practitioner let them know they entered an order. They stated they periodically checked the system for orders and would enter the order into the laboratory system. An order requisition was printed from the laboratory system and placed in a binder for the phlebotomist to identify the resident and the test needed to be drawn. The phlebotomist comes on Monday, Wednesday, and Friday, usually early around 6:00 AM and leaves the facility around 7:30 AM. During an interview on [DATE] at 12:14 PM, the Medical Director stated they were not very familiar with Resident #118. The surveyor discussed the concerns with the laboratory orders and the outcome to the resident. The Medical Director stated there was a delay in diagnoses due to a lack of collecting the laboratory specimens. They stated there was no harm though because the resident did not have a heart attack or stroke and stated that other than shortness of breath for a couple of weeks, there was no adverse effect from the delay. They stated there should be a system in place to reconcile laboratory orders. If Nurse Practitioner #1 felt the laboratory tests were an emergency, they should have spoken to a nurse about it. During an interview on [DATE] at 12:33 PM, Administrator #1 stated if there was a physician order for a laboratory test, the specimen should be drawn, and the test completed and resulted. 10 New York Codes, Rules, and Regulations 415.12

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	05/13/2026

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 0770 Level of Harm - Actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during survey, the facility failed to obtain physician ordered laboratory tests to meet the needs of its residents for one (1) (Resident # 118) of three (3) residents reviewed. Specifically, the laboratory test ordered for Resident #118 on [DATE] and [DATE] were not completed as ordered. The laboratory test was not completed until it was ordered for a third time on [DATE], which resulted in critical levels requiring hospitalization for a blood transfusion. This resulted in actual physical harm for Resident #118 that was not Immediate Jeopardy. Findings include: Cross-referenced to F656: Develop/Implement Comprehensive Care Plan Cross-referenced to F684: Quality of Care The undated facility policy and procedure titled, Request for Diagnostic Services, documented all requests for diagnostic services must be ordered by the resident's attending physician. All orders for diagnostic services must be entered into the resident's medical record and signed by the attending physician. Orders for diagnostic services would be promptly carried out as instructed by the physician's order. Emergency requests must be labeled stat to assure prompt action was taken. The undated facility policy and procedure titled, Test Results, documented the resident's Attending Physician would be notified of the results of diagnostic tests. Results of laboratory tests would be reported in writing to the resident's Attending Physician. Should the tests results be provided to the facility, the Attending Physician would be promptly notified of the results. The Director of Nursing Services or Charge Nurse receiving the test results would be responsible for notifying the physician of the test results. Signed and dated reports of all diagnostic services would be made a part of the resident's medical record. The facility policy and procedure titled, Continuity of Care, revised 05/2025, documented quality of care was a fundamental principle that applied to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Nurses were expected to follow valid orders from physicians or other authorized healthcare providers. Resident #118 Resident # 118 was admitted to the facility with diagnoses of unspecified anemia (blood has insufficient red blood cells or hemoglobin and the cause is unknown), atrial fibrillation (irregular heart rhythm) and unspecified anxiety disorder. The Minimum Data Set (a resident assessment tool) dated [DATE], documented the resident had an active diagnosis of anemia, was cognitively intact, was able to make themselves understood, and usually understood others. There was no documented evidence of a comprehensive care plan for the diagnosis of anemia. The Medical Progress Note dated [DATE] by Nurse Practitioner #1, documented Resident #118 was seen on [DATE], and they would order laboratory tests to check their hemoglobin (a protein in the blood that carries oxygen) level. The Physician Orders report from [DATE] to [DATE], documented: On [DATE] at 1:56 PM, a one-time Laboratory Request Order for a complete blood count (blood test that measures the number and types of cells circulating in your blood) for diagnosis of unspecified anemia. On [DATE] at 3:52 PM, this order was discontinued and documented as the order having been replaced. On [DATE] at 3:52 PM, a one-time Laboratory Request Order for a complete blood count and magnesium level for diagnosis of unspecified anemia. On [DATE] at 7:51 AM, this order was discontinued and documented as the order having been replaced. On [DATE] at 7:51 AM a one-time Laboratory Request Order for a complete blood count and magnesium level for diagnosis of unspecified anemia. On [DATE] at 10:13 AM, the order was discontinued and documented as the order having been replaced. On [DATE] at 10:13 AM, a one-time Laboratory Request Order for a complete blood count and magnesium level for diagnosis of unspecified anemia. There was no documented evidence of laboratory test results for a complete blood count and magnesium level dated [DATE] or [DATE]. The [DATE] Nurse Practitioner #1 progress note documented they saw the resident for evaluation of their pain, chronic obstructive pulmonary disease and their routine 30-day facility (continued on next page)

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F 0770 Level of Harm - Actual harm Residents Affected - Few	follow-up. Diagnoses included iron deficiency anemia with a plan including continue ferrous sulfate (iron supplement) and waiting for appointment with hematology. There was no documentation in the note dated [DATE] by Nurse Practitioner #1 about the status of the laboratory tests for the complete blood count and magnesium. There were no nursing progress notes dated from [DATE] to [DATE]. There were no progress notes dated [DATE] to [DATE]. The progress note dated [DATE] by Nurse Practitioner #1, documented that they saw the resident on [DATE] at the request of nursing to follow-up on the resident's shortness of breath. The resident reported they had some increased shortness of breath with exertion. Plan documented they would have respiratory come and evaluate them. They discussed that the shortness of breath could also be due to other reasons as they did have quite a bit of anxiety. The laboratory results for Resident #118 dated [DATE] at 1:04 PM documented for the complete blood count: the white blood cell count was low, the red blood cell count was low, and hemoglobin was low. It further documented hemoglobin was at 4.6 g/dL, indicated it was a priority and was outside of the normal reference range of 11.7 - 15.5 g/dL. Additionally, hematocrit (measures how much of the blood consists of red blood cells) was low at 15.6 percent, outside of the normal reference range of 35.9 - 46.0 percent. The nursing progress note dated [DATE] at 1:52 PM by Assistant Director of Nursing #2 documented they received a call from the laboratory with critical lab values. Resident #118's hemoglobin level was critically low at 4.5, and white blood count was critically low at 2.2. Upon assessment the resident reported feeling fatigued and generally unwell. An order was obtained to send the resident to the hospital. Notified attending nurse practitioner of the results and received an order to send the resident out (to the hospital) for emergency transfusion. The hospital History and Physical dated [DATE] documented the resident reported a history of chronic anemia and noticed worsening shortness of breath with exertion for the last one to two weeks, suspected their anemia was worse, and requested the provider repeat the laboratory work. Assessment and Plan included acute on chronic anemia (a sudden and rapid decrease in red blood cells) and a transfusion of red blood cells was in progress. The shortness of breath on exertion was likely secondary to symptomatic anemia (occurs when a drop in red blood cells or hemoglobin reduces oxygen delivery to the organs and causes tiredness, weakness, or shortness of breath). The Hospital Discharge summary dated [DATE], documented the resident had a history of chronic anemia requiring multiple transfusions of blood, vitamin B12 shots, and iron infusions in the past. The resident reported to the facility for approximately two weeks that they had been fatigued, experiencing weakness with some leg tenderness, which they recognized as signs that their blood was low. There was no laboratory work done at the facility until just prior to admission to the hospital on [DATE]. The resident was given two units of red blood cells in the Emergency Department and a repeat complete blood count showed correction of the hemoglobin to 7.6 and 23.8 for the hematocrit. The resident was admitted to the inpatient floors for monitoring of acute on chronic anemia. The nursing progress note dated [DATE] at 3:00 PM by Registered Nurse #10 documented the resident was readmitted to the facility from the hospital on [DATE], with diagnosis of pancytopenia (low levels of red and white blood cells and platelets (cells that clot blood). During an interview on [DATE] at 3:03 PM, Resident #118 stated they had a medical condition and required iron supplements and B12 injections. They said they had been to the hospital 13 times to figure out why they were losing blood and eventually discovered they were not making enough blood. Resident #118 was hospitalized in [DATE] for five days and received multiple units of blood. Prior to this hospitalization in [DATE], Resident #118 stated that it took them four weeks for staff to do blood work when they complained of feeling weak. The resident stated, I was very sick. I could have died. During an interview on [DATE] at 10:32 AM, Family Member #1 stated they were praying the facility was currently doing the resident's bloodwork on time, which should be every two weeks because the resident had anemia and received iron. Prior to the resident's hospitalization on [DATE], they spoke with the social worker and Assistant Director of Nursing #2 on separate occasions in the beginning of [DATE] about the bloodwork that needed to be done for the resident's diagnosis of anemia and they (continued on next page)

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F 0770 Level of Harm - Actual harm Residents Affected - Few	were told they would take care of it.ˆFamily Member #1 stated they were very concerned about the resident getting the proper care that they needed at the facility. During an interview on [DATE] at 4:53 PM, Assistant Director of Nursing #2 stated they managed the 5th floor unit. Nurse Practitioner #1 saw Resident #118 on [DATE]. Resident #118 had anemia and Nurse Practitioner #1 entered an order in the computer system for a laboratory test to check their hemoglobin levels. For reasons unknown, the phlebotomist (healthcare professional who draws blood and other specimens) did not come into the facility to draw the resident's blood (collect the specimen). There was supposed to be a follow up done to ensure laboratory tests were drawn but they were not made aware and therefore did not follow up. Assistant Director of Nursing #2 stated they were not made aware until it was far later than it should have been. On [DATE], they were notified by the laboratory that the resident's hemoglobin level was critically low. The resident was not feeling well and was sent to the hospital.ˆThey stated the first symptom they recalled the resident having was the resident wanting something for asthma and it did not occur to them that the resident was short of breath. That was a few days prior to [DATE]. Assistant Director of Nursing #2 thought it was respiratory related and did not follow up on it. They stated they did not make a connection with the shortness of breath to the anemia until they received the laboratory results on [DATE]. ˆ During an interview on [DATE] at 5:18 PM, Nurse Practitioner #1 stated they were extremely familiar with Resident #118. The resident had a diagnosis of anxiety and expressed their concerns daily. The resident first started talking about their anemia in February or [DATE].ˆThey saw the resident on [DATE] and ordered a laboratory test to check the status of the resident's chronic anemia. The specimen for the laboratory test was not drawn, and they did not know why. They explained the process for ordering a laboratory test. Nurse Practitioner #1 entered the order into the electronic medical record system and then the nurse or ward clerk had to enter the order into the laboratory computer system to alert them of the order. The nurse or ward clerk would then print the laboratory requisition for the order(s) from the laboratory computer system and would put the requisition in a binder for the phlebotomist. The phlebotomist came into the facility on Monday, Wednesday, and Friday to collect specimens, or would come if something was ordered urgently. The phlebotomist was supposed to look in the binder for the requisition and then collect the specimen. They were not sure if the order they entered on [DATE] was entered into the laboratory computer system or if the phlebotomist missed the requisition for it. They reviewed the orders and stated it looked like they put the order in for the laboratory test a couple times and it finally got drawn on [DATE].ˆThey stated the ward clerk was responsible for ensuring a laboratory test was ordered in the laboratory computer system and then drawn.ˆThey did not know who provided oversight for the process of ordering laboratory tests. The resident was sent to the hospital on [DATE] and had blood transfusions.ˆ During an interview on [DATE] at 11:45 AM, Director of Nursing #1 stated if a provider placed an order for a laboratory test independent of the nurse manager, the manager would not know it was in the computer system and needed to be drawn. The laboratory obtained blood specimens on Monday, Wednesday, and Friday. If the test was ordered after 3:00 PM, the laboratory would not be alerted that a specimen needed to be drawn. The Director of Nursing #1 reviewed the orders and stated a complete blood count was ordered on [DATE] at 3:52 PM. This would have been too late to be drawn the next day, Friday. Nurse Practitioner #1 put in another order for a complete blood count on [DATE] at 7:51 AM, a Friday and again the specimen was not drawn because the phlebotomist was in and out of the building relatively quickly. They stated they had experienced issues with the laboratory and there were process improvement plans. If Assistant Director of Nursing #2 was not made aware of the need for the laboratory test, they would not know they had to follow up. During an interview on [DATE] at 12:03 PM, [NAME] Clerk #3 stated they were responsible for reviewing the electronic medical record for laboratory orders. The nurse practitioner entered the order in the electronic medical record system. They checked the system for orders, or the nurse practitioner let them know they entered an order. They stated they periodically checked the system for orders and would enter the order into the laboratory system. An order requisition was (continued on next page)

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F 0770 Level of Harm - Actual harm Residents Affected - Few	printed from the laboratory system and placed in a binder for the phlebotomist to identify the resident and the test needed to be drawn. The phlebotomist comes on Monday, Wednesday, and Friday, usually early around 6:00 AM and leaves the facility around 7:30 AM. During an interview on [DATE] at 12:14 PM, the Medical Director stated they were not very familiar with Resident #118. The surveyor discussed the concerns with the laboratory orders and the outcome to the resident. The Medical Director stated there was a delay in diagnoses due to a lack of collecting the laboratory specimens. They stated there was no harm though because the resident did not have a heart attack or stroke and stated that other than shortness of breath for a couple of weeks, there was no adverse effect from the delay. They stated there should be a system in place to reconcile laboratory orders. If Nurse Practitioner #1 felt the laboratory tests were an emergency, they should have spoken to a nurse about it. During an interview on [DATE] at 12:33 PM, Administrator #1 stated if there was a physician order for a laboratory test, the specimen should be drawn, and the test completed and resulted. 10 New York Code of Rules and Regulations 415.20

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during the survey, the facility failed to ensure residents received routine and/or emergency dental services, including assistance in obtaining dental evaluation and treatment for two of three residents (Resident #155 and #162) reviewed. Specifically, (1.) Resident #155 was discovered to have a broken front tooth by family and was not referred to dental services to rule out any potential issues/problems. (2.) On 04/15/2026, Resident #162 was known to be missing upper dentures but their diet was not adjusted to account for this factor until five days later on 04/20/2026, when a dental consult documented to adjust diet as needed. Resident #162's full upper denture impressions were not completed until 05/10/2026. The delay in dental follow-up and denture replacement had the potential to impact the resident's ability to chew, nutritional status, and overall oral health. Findings include: The facility policy titled In-House Dental Services Coordination Process reviewed 06/03/2025, documented the purpose was to ensure timely, coordinated, and documented access to in-house dental care services for residents, enhancing oral health and meeting regulatory standards. Procedure: (1.) Identification and Referral: Licensed staff who identified a resident's need for dental evaluation must report it to the assistant unit manager, unit manager, supervisor, or ward clerk. The patient would then be added to the Dental Service Tracking Sheet located in the O- Drive and a dental consultation sheet would be filled out for the resident. (2.) Scheduling and Confirmation: the on-site clinic staff would review the Dental Services Tracking Sheet regularly and ensure the on-site dental provider had an updated list when at the facility. (3.) Documentation, Communication, Monitoring: After the patient was seen, the clinic staff was responsible for updating the Dental Services Tracking Sheet, providing the consultation sheet to the attending provider for review and signature, and uploading it to the resident's chart. The assistant unit manager/unit manager were responsible for placing a note in the residents' chart with a brief review of the consult, recommendations, and any necessary follow up and ensuring communication with the resident. Resident #162 was admitted to the facility with diagnoses of Encounter for atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), hypo-osmolality (concentration of dissolved particles such as sodium, glucose, and urea in the blood or other body fluid is lower than normal) and hyponatremia (a condition where sodium levels in the blood are too low), and depression (a mental health condition characterized by persistent sadness, loss of interest, and other symptoms that significantly impair daily life). The Minimum Data Set (a resident assessment tool) dated 02/25/2026, documented that the resident could be understood, could understand others and had intact cognition for daily living decisions. A lost/missing item report completed for Resident #162 dated 04/15/2026, documented Family Member #1 reported the resident's upper dentures were missing. Dentures were not found. It further documented Resident #162 was seen by the dentist on 04/20/2026 and the process was started for new upper dentures. A dental consult dated 04/20/2026, documented evaluation lost full upper dentures. Adjust diet as needed. There was no documentation that indicated impressions were taken or new dentures were ordered for Resident #162. A nursing progress noted written by Licensed Practical Nurse #4, dated 04/20/2026, documented Resident #162 was seen by the dentist to see if full upper dentures could be made. The dentist was going to get insurance approval then start the process. The resident denied pain. A nutrition progress note written by Diet Technician #2 dated 04/21/2026 at 8:23 AM, documented visited Resident #162 and they reported they lost their upper dentures. Meal plan adjusted to softer food. Resident #162 only wanted ground chicken until dentures were restored. Resident #162's Comprehensive Care Plan for Nutrition dated 03/11/2026 documented the resident was on a regular diet with regular consistency. Interventions included set up, open containers, cut up meat, butter bread. During an interview on 05/05/2026 at 11:05 AM, Resident #162 stated they lost their upper dentures a while ago and a diet technician came to see them who advocated for them to (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have ground meat. Resident #162 stated breakfast was usually good, but they did not get what they preferred, which was ground meat for lunch and dinner. Resident #162 stated their dentures were supposed to come back 3 weeks ago but never did and is not sure what is going on with their missing dentures but would like them back. During an observation on 05/05/2026 at 1:00 PM, Resident #162 did not have upper dentures in their mouth. The resident was observed to have uncut roast beef for lunch. During an interview on 05/05/2026 at 1:00 PM, Resident #162 stated their upper dentures had been missing for months. They stated they were seen by the dentist 2 weeks ago to make a full upper impression but had not heard anything further. They stated they were on a regular diet but could not chew the uncut roast beef that was served for lunch. During an interview on 05/05/2026 at 1:00 PM, Resident #162' s Personal Care Aide #1 stated the resident's dentures had been missing since they started working with Resident #162 a couple months ago. They stated the food never reflected the meal ticket and the resident's diet was never changed to mechanical soft. During an interview on 05/07/2026 at 3:14 PM, Social Worker #1 stated they received a call from Family Member #1 on 04/14/2026 or 04/15/2026 who informed them that Resident #162's upper dentures were missing. Social Worker #1 went to Resident #162's room to search for the dentures although Resident #162 was asleep at the time. Social Worker #1 stated they found the dentures in the resident's laundry then placed them on the resident's tray table so they would see them when they woke up. Social Worker #1 stated they attempted to wake the resident to inform them that the dentures were found but they would not wake up. The next day Social Worker #1 went to Resident #162's room in the morning to let them know the dentures were found in their room and the resident said they did not see them when they woke up from their nap the previous day. Social Worker #1 stated they filled out a missing items report and notified Registered Nurse #2 who then contacted the dentist. They stated the in-house dentist saw Resident #162 on 04/20/2026. Missing Items reports were filled out and given to Corporate Director of Care Transition who completed the investigation. They stated the process on missing items was to first ask the residents for permission to search their room, call security, try to locate the item then fill out a missing items report if the item could not be found. Social Worker #1 stated if a resident was asleep, they would still search their room. During an interview on 05/08/2026 at 11:27 AM, Diet Technician #1 stated they would see residents if the nurse brought up issues or if there were any changes in conditions. Diet Technician #1 saw Resident #162 on 04/21/2026 and made a recommendation for ground chicken which was documented in a progress note. They stated that when residents were missing dentures, the diet would most likely be changed to ground depending on the resident's chewing ability, although some residents were able to do chopped or softened. Certified nurse aides were responsible for documenting how much residents ate and drank. Diet Technician #1 stated at that time there were no concerns for Resident #162. During an interview on 05/08/2026 at 1:04 PM, Registered Nurse #2 stated Social Worker #1 notified them a couple weeks ago that Resident #162's upper dentures were missing. Registered Nurse #2 stated they assessed Resident #162 to make sure they did not have difficulty chewing or eating. Registered Nurse #2 checked the electronic medical record to see if they documented their assessment and confirmed they did not. They stated they did a quick sweep of the room to look for the dentures but did not see them and put a request in the system for a dental consultation. If items went missing, it was reported to the Social Worker on the floor who followed through with the report. Registered Nurse #2 stated they were waiting to hear back from Resident #162's dental insurance regarding denture coverage. They stated when the dentist came to the facility, Licensed Practical Nurse #2 rounded with the dentist and let them know when anything needed to be done. During an interview on 05/12/2026, at 12:46 PM, Licensed Practical Nurse #6 stated they primarily worked in the clinic on the second floor. Licensed Practical Nurse #6 stated that when Dentist #1 came to the facility, they accompanied Dentist #1 to resident rooms. Licensed Practical Nurse #6 stated Dentist #1 was the only dentist who examined residents for dentures and performed denture-related services. Dentist #2 performed examinations and sent referrals for hygiene appointments. Licensed Practical Nurse #6 stated dental (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cleanings were typically completed in Rochester, New York, because surrounding areas did not accept geriatric residents and their insurance. Licensed Practical Nurse #6 stated that, previously, the denture process had taken up to four months from start to completion but was unsure of the current timeframe since the facility had hired a new dentist who also came to the facility on weekends if needed. Licensed Practical Nurse #6 stated that on 03/05/2026, Dentist #1 saw Resident #162 for a routine initial examination. Resident #162 had full upper dentures, crowns on teeth numbers 22 through 27, and retained root tips on teeth numbers 21 and 28. No recommendations were made at that time. Licensed Practical Nurse #6 stated that on 04/20/2026, Resident #162 was seen for missing upper dentures. Licensed Practical Nurse #6 stated Dentist #1 had discussed adjusting the resident's diet as needed with the Nurse Manager and Dietician; however, because the resident was not exhibiting any signs of difficulty, no diet changes were made. Licensed Practical Nurse #6 stated Dentist #1 had only come to evaluate the resident at that visit. Licensed Practical Nurse #6 stated that on 05/10/2026, Resident #162 was again seen for missing upper dentures, and impressions were completed at that time. During an interview on 05/12/2026, at 4:00 PM, Dentist #1 stated they had begun working at the facility in March 2026 and had visited the facility several times since then. Dentist #1 stated they were often at the facility checking on residents two to three times per month and planned to work at the facility five to six times per month once the dental clinic room was operational, as the facility was in the process of renovating it. Dentist #1 stated impressions for full upper dentures had been taken for Resident #162 on 05/10/2026 and had been sent to the laboratory. Dentist #1 stated they had discussed with Resident #162 that one additional appointment would be needed for a denture fitting and that the dentures would be completed approximately one week to ten days afterward. Dentist #1 stated they were unsure how Resident #162's dentures had gone missing but stated they would expedite the denture process once the dentures were completed. Dentist #1 stated, if the laboratory work was returned and the visit has not been coordinated, even if they were not scheduled, they would come in to see the resident, even if it was only for that resident. They were hoping the dentures would be completed within two weeks. Typically, it took four to six weeks to complete dentures from beginning to end, but they would try to expedite the process whenever possible. Dentist #1 further stated that if the resident was discharged prior to completion of the dentures, they would continue to follow through to ensure Resident #162 received the dentures and would notify the family. Dentist #1 stated the second visit on 04/20/2026, had been for an examination related to the resident's missing dentures. Dentist #1 stated they were unsure why impressions had not been made during that visit. Resident #155 Resident #155 was admitted to the facility with diagnoses of fracture of sacrum (a break or crack in the large triangular bone at the base of the spine that connects the spinal column to the pelvis), fracture of superior rim of right pubis (a break in the upper front part of your pelvic ring), and dementia (a group of conditions that cause a progressive decline in cognitive abilities). The Minimum Data Set, dated [DATE], documented the resident usually understood others, was usually understood by others, and had severe cognitive impairments. A complaint received by the New York State Department of Health on 03/16/2026 at 3:00 PM, documented family went to visit Resident #155 on 02/17/2026 and noticed they had damaged teeth. Resident #155 had a front tooth cracked in half with exposed roots, visible to the gum, and several cracked teeth in the back. Resident #155 thought they fell but was not sure, and when asked if their teeth were bothering them the resident said yes. Nursing staff were unaware of the broken teeth or what happened. Family met with the Director of Social Work and filed a grievance requesting that an investigation be completed to determine the cause. The facility had not responded to the family's multiple requests for follow-up. The family was still unaware of the outcome of the grievance that was filed on 02/17/2026, or if the resident was seen by the dentist. Family was concerned that the cracked teeth might be related to poor dentation. A Complaint/Grievance Investigation form received 02/17/2026, documented Resident #155's grievance/complaint was: claims resident had a cracked tooth. The corrective action included resident seen by Registered (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse Unit Manager, no chipped/cracked teeth noted. Family was notified of the results on 03/16/2026. The Grievance Log 2026, documented the date of grievance for Resident #155 was 02/17/2026. The grievance/concern documented resident had a cracked front tooth. The resolution was the resident does not have a cracked tooth. The date the complainant was notified was 03/16/2026. A nursing progress note dated 03/16/2026, written by Registered Nurse #2 documented Resident #155 was alert with some confusion at baseline, but able to make needs known. Resident #155 denied pain or discomfort, Resident #155's oral mucosa was pink and intact. Teeth intact; no sharp edges or cracks noted. Skin intact with no reddened or open areas noted. Plan of care ongoing. An undated Dental Consultation Sheet signed 10/15/2025, documented it was an initial exam for Resident #155. It was documented that the resident had a history of many crowns, which were identified in the picture. There was no documentation to indicate that Resident #155 had chipped, fractured, or root tips. There was no documentation that Resident #155's front left tooth had any issues or concerns. There were no additional dental consultations for Resident #155. A Care Conference Summary note dated 04/21/2026, documented under nursing services, an order was added for Resident #155 to see the dentist. As of 05/08/2026 there was no documented evidence that a new order for a dental consultation was added to Resident #155's physician orders. During an observation on 05/05/2026 at 1:06 PM, Resident #155 opened their mouth and half of their left front tooth was observed to be missing. During an observation on 05/12/2026 at 3:50 PM, a foul smell was noted coming from Resident #155's mouth when observing their teeth. During a telephone interview on 05/06/2026 at 9:50 AM, Family Member #3 stated when they went to visit Resident #155 in mid-February, they discovered that one of the resident's front teeth was chipped. At the time, the resident had stated their teeth kind of hurt and that they had been spitting cracked pieces of their tooth on the floor. Resident #155 told them they had fallen, but the resident had dementia, so they were unsure what happened. Family Member #3 stated they attempted to talk with staff on the floor, but could not locate the unit manager, or the residents' regular Certified Nurse Aide or Licensed Practical Nurse. They stated they met with the Director of Social Work and filed a grievance. They wanted to know what happened to cause the broken tooth and wanted to have Resident #155 seen by the dentist. They stated Resident #155 had still not been seen by the dentist. During an interview on 05/08/2026 at 11:08 AM, Certified Nurse Aide #2 stated they could not remember if Resident #155's tooth was always like that. They stated they were out of work for a couple months, so they were not sure if something happened during that time. During an interview on 05/08/2026 at 11:18 AM, Licensed Practical Nurse #1 stated they were not aware of Resident #155 having a chipped or broken tooth. They stated if they noticed a chipped/broken tooth they would report it to the manager right away. Licensed Practical Nurse #1 reapproached this surveyor at 11:55 AM and stated that Resident #155's tooth had been like that and they just never noticed. During an interview on 05/08/2026 at 11:34 AM, Registered Nurse #2 stated when family complained about Resident #155's teeth being cracked, they assessed the resident, and there were no cracks. They stated Resident #155 did not have any pain or difficulty chewing. They stated family said the resident had a chipped tooth and wanted them seen by dental. They stated they believed they put in a dental consult. They stated dental was at the facility once a month and it took no time to put in a consult. They stated they had written a progress note on 03/16/2026 and there were not sharp edges, cracks, or open areas noted. Registered Nurse #2 went with this surveyor to look at Resident #155's teeth. Registered Nurse #2 looked at the residents' teeth and stated it did not look like that when I assessed them. During an interview on 05/11/2026 at 2:59 PM, Social Worker #1 stated they wrote up a grievance in February for Resident #155. It was about a chipped tooth, not being toileted after meals, and not being up in the morning. Family met with Social Worker #1 and Director of Social Work #1 to file the grievance. Social Worker #1 could not remember if there was a specific tooth that was chipped. They stated family was going to find their own dentist and not use the facility's dentist. During an interview on 05/12/2026 at 12:23 PM, Licensed Practical Nurse #4 stated they were responsible for putting together the list of (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents that needed to be seen by the dentist and they did rounds with the dentist when they came in. They stated the facility recently had a new dentist start, so now the facility has 2 dentists. They stated the dentists come to the facility once or twice a month. Licensed Practical Nurse #4 stated residents received an initial dental consult on admission, and then yearly and as needed. They stated the dentist typically checked to see if the resident had any open areas or infections and if further work was needed would refer them out. Licensed Practical Nurse #4 stated when looking at the dental consults, a circle indicated a crown, an x indicated a missing tooth, a fx (fracture) indicated a chipped tooth or half a tooth, and triangles indicated a root tip. Licensed Practical Nurse #4 stated they were responsible for entering any orders given and uploading consults to the electronic medical record after a dental visit. When reviewing Resident #155's electronic medical record, they stated the resident was seen on 10/10/2025 for their initial consult and had not been seen since then. They further stated there were no new orders for dental consult for Resident #155. Licensed Practical Nurse #4 stated the last time a dentist was in was 04/20/2026. When reviewing Resident #155's initial consult, they stated there was no indication that the residents top front teeth were fractured or had root tips. During an interview on 05/12/2026 at 12:00 PM, Registered Nurse #11 stated if a resident had a cracked tooth, they would investigate to see when and how it occurred. They would complete an incident and accident report. They stated they would want to make sure the resident was eating okay, would put in a speech therapy evaluation and occupational therapy evaluation. They stated they would put in the consult and have them seen by the dentist. The stated the consult would indicate if there were any issues/problems after the resident was seen. During an interview on 05/12/2026 at 1:49 PM, Assistant Administrator #1 stated one of the grievances filed for Resident #155 was about their teeth being chipped. They stated the nurse assessed Resident #155 and did not find any cracked teeth. If they had found cracked teeth, they would refer them to the dentist and try to investigate why there was a cracked tooth. During an interview on 05/13/2026 at 10:25 AM, Dentist #2 stated they usually saw patients at bedside, completed an oral screening, charted any teeth missing or broken, or if there was a bridge or crown. A broken tooth or root tip was identified with a blue or red triangle on their consult. They stated they would document if a patient was missing part of their tooth. Dentist #2 stated the facility usually set up a consult if a resident had a filling fall out or a chipped tooth. If there were sharp edges they might be able to smooth them off. If it was not restorable, they would say that in their consult and leave it alone. Dentist #2 stated usually if a patient had a chipped tooth, they would say they wanted a consult and it would be put in. During an interview on 05/13/2026 at 12:01 PM, Administrator #1 stated if a resident had a chipped or broken tooth they would want a Registered Nurse to take a look, the medical provider involved, and a referral made to the dentist. 10 New York Codes, Rules, and Regulations 415.17(a-d)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on record reviews and interviews conducted during survey, the facility failed to provide residents with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs for one (Resident #412) of three residents reviewed. Specifically, the facility failed to ensure overall systems were established for documentation of all meals by nursing staff and were being maintained according to standards of practice and facility policy when they failed to document breakfast, lunch, and dinner for Resident #412 between the dates of 11/01/2025 through 11/30/2025. Findings include:Resident #412 was admitted to the facility with diagnoses of osteomyelitis of vertebra, lumbar region (a serious infection of the bones in the spine,) acute and subacute infective endocarditis (a life-threatening infection of the heart's inner lining or valves,) and Type 2 Diabetes mellitus, without complications (a disease that affects how the body uses blood glucose (sugar). The Minimum Data Set (a resident assessment tool) dated 11/04/2025 documented that they could make themselves understood and understood others and were cognitively intact. Review of the facility's policy and procedure titled Fine Dining Policy dated 09/2025 stated Nursing staff are required to document meal consumption. A review of Resident #412's Certified Nurse Aide Meal Documentation record for the month of November 2025, did not include documentation of resident meals for the following meals and dates:Breakfast for the dates of 11/04/2025, 11/05/2025, 11/08/2025, 11/12/2025, 11/15/2025,11/18/2025, 11/20/2025, 11/21/2025, 11/22/2025, 11/23/2025, 11/30/2025Lunch for the dates of 11/01/2025, 11/02/2025, 11/03/2025, 11/04/2025, 11/06/2025, 11/07/2025, 11/08/2025, 11/09/2025, 11/10/2025, 11/12/2025, 11/13/2025, 11/14/2025, 11/15/2025, 11/16/2025, 11/19/2025, 11/20/2025, 11/21/2025, 11/22/2025, 11/23/2025, 11/24/2025, 11/25/2025, 11/26/2025, 11/27/2025, 11/30/2025Dinner for the dates of 11/03/2025, 11/04/2025, 11/06/2025, 11/07/2025, 11/11/2025, 11/14/2025, 11/16/2025, 11/17/2025, 11/18/2025, 11/19/2025, 11/22/2025 During an interview on 05/12/2026 at 12:18 PM, Licensed Practical Nurse #3 stated that meals and snacks are documented in the electronic health record. They stated that each shift tracks its own meals and snacks and are expected to be documented for each meal. During an interview on 05/12/2026 at 12:24 PM, Certified Nurse Aide #9 stated all meal intakes were to be documented in their electronic medical record system (charting system on a kiosk) for every one of their residents. 10 New York Codes, Rules, and Regulations 415.14(f)(1)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on observation, record review, and interviews conducted during survey, the facility failed to provide drinks, including water and other liquids, consistent with resident needs and preferences and sufficient to maintain resident hydration for one (Resident # 118) of three residents reviewed. Specifically, the facility failed to ensure Resident #118 received water and ice per their preference to maintain hydration. Findings include: Resident #118 Resident # 118 was admitted to the facility with diagnoses of unspecified anemia (low levels of healthy red blood cells and can cause tiredness, weakness, and shortness of breath), urinary tract infection, and adult failure to thrive (a state of decline that manifests as weight loss, decreased appetite, poor nutrition, and inactivity). The Minimum Data Set (a resident assessment tool) dated 02/26/2026, documented the resident was cognitively intact, was able to make themselves understood, and usually understood others. The Policy and Procedure titled, Nourishment Program Policy and Procedure, dated 10/06/2025, documented it was the policy of the facility to ensure all residents had access to and received appropriate nourishments, snacks, supplements, fortified foods, and hearty snacks to maintain or improve nutritional and hydration status, in compliance with regulatory requirements and individualized care plans. The nourishment pass was defined as the planned delivery of nourishments at designated times between meals, based on resident diet order and care plan. The nourishment pass ensured that residents had consistent opportunities to meet nutritional and hydration needs. Nourishments were passed by the Certified Nurse Aide following delivery to the unit at approximate times of 10:00 AM, 2:00 PM, and HS (hour of sleep, bedtime). The Policy and Procedure titled, Clinical Nutrition, revised 08/2020, documented nutrition and nursing staff determined the hydration needs of all residents and identified those residents at risk for dehydration so that appropriate interventions were implemented. Nursing staff would provide water for residents three times each day in addition to between meal nourishments. The Comprehensive Care Plan for Nutrition, revised 02/25/2026, documented the resident would remain well hydrated as evidenced by no signs/symptoms of dehydration, laboratory test results withing acceptable limits. Approaches (interventions) included thin liquids. During an interview and observation on 05/05/2026 at 3:03 PM, Resident #118 showed the surveyor their water pitcher that was empty and had no lid. Resident #118 stated the lid broke today, and they told their certified nurse aide, who never came back with a new lid.ˆ During an interview and observation on 05/06/2026 at 11:15 AM, Resident #118 stated they did not get a new lid for their water pitcher. The pitcher was on the nightstand, had no lid, and was empty. The resident stated they had no water to drink, and staff never filled the pitcher with water last evening/night. They thought about going to the dietary department to get a new lid but were not feeling strong enough. They stated staff did not bring water to them unless they asked for it. Resident #118 stated they liked water and ice. They had to drink the water from the bathroom on several different occasions because staff did not bring water to them. During an interview on 05/07/2026 at 10:32 AM, Resident #118 stated they finally received a lid for their water pitcher after telling staff the State was here, and they would get in trouble if they did not give them a lid. Staff brought a lid but did not bring water/ice. They stated they had to fill their travel cup with bathroom water, which disgusted them. They had to walk down to the kitchenette this morning to get their own water/ice. They stated they had not seen an aide at all this morning.ˆ During an interview on 05/11/2026 at 10:14 AM, Certified Nurse Aide #23 stated they were responsible for ensuring residents had water/ice available when rounding and per their care plan, which was typically every two (2) hours. The aide should learn the resident's needs and wants by building rapport, so they were able to anticipate their needs. There was a hydration policy, and they were unsure if there were specific times in the policy that water/ice should be brought to the residents or the specifics of the policy. During an interview on 05/11/2026 at 10:52 AM, Certified Nurse Aide #24 stated they were responsible for ensuring the residents had water (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and ice available to them. They made rounds on the residents to check the water pitchers. They also checked the water pitchers when they provided care to a resident. Some residents rang their call bell if they needed water and others needed to be encouraged to drink. If they noticed physical symptoms like dry lips, they would encourage the resident to drink water. They were aware of the facility's policy on hydration and stated they should check the resident every two hours for hydration/water, especially for residents who could not make their needs known. During an interview on 05/11/2026 at 10:56 AM, Certified Nurse Aide #25 stated they were responsible for ensuring the residents had water on the bedside table and would ask the resident if they had water. If the resident could not make their needs known, they would ensure the water pitcher was full, ask them if they wanted some water and would encourage them to drink. They looked for physical signs such as dry mouth and urine output (color and odor). They would ensure they mentioned it to the nurse manager if urine odor was strong and they noted a decrease in fluid intake. They documented fluid intake in the electronic medical record system where meal intakes were documented. The policy was for residents to stay hydrated. During an interview on 05/11/2026 at 11:04 AM, Certified Nurse Aide #26 stated they made sure the residents on their assignment had their water pitchers filled with water and ice two times per shift. They were unsure if there were policies and procedures for hydration and just knew the residents should be drinking throughout the day. They documented meal and fluid intake in the electronic medical record. During an interview on 05/11/2026 at 11:14 AM, Licensed Practical Nurse #8 stated when they reported to work in the morning, they made sure the residents had water and ice available. They rounded on the residents to ensure they had water available, sometimes every two hours. If a resident could not make their needs known, for example with aphasia (language disorder that affects ability to speak and understand what others say) they used a picture board to let staff know they were thirsty. They were unsure if there was a hydration policy and did not know what would be in it. During an interview on 05/12/2026 at 4:53 PM, Assistant Director of Nursing #2 stated they managed the 5th floor unit. The certified nurse aides should be bringing water to the residents every shift and supplementally between meals. 10 New York Code of Rules and Regulations 415.14(d)(4)

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F 0809 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observations, record review, and interviews conducted during survey, the facility failed to ensure that meals were provided at regular times comparable to normal mealtimes in the community, nor did the facility provide suitable, nourishing alternative snacks for residents waiting for meals. Specifically, dinner service on 05/11/2026, on the 4th floor took over two hours to complete, resulting in residents sitting at tables waiting for food while others ate, and the snack pantry was found to be without nourishing options. This was evident for all residents on the 4th floor. Findings include:The facility policy and procedure titled, Fine Dining, last revised on 09/2025, documented that mealtimes have a positive impact on the resident's physical, psychological, emotional, and social well-being. Mealtimes will be as follows: breakfast at 7:30 AM, lunch at 12:00 PM, and dinner at 5:30 PM. A document titled, Meal Times, stated the mealtimes for breakfast were 7:30 AM through 9:00 AM, lunch at 12:00 PM through 1:30 PM, and dinner at 5:30 PM through 7:00 PM. Review of a photograph taken of a schedule titled, Resident Rooms - Kitchen Tray Line Service, showed unit-by-unit meal schedules for breakfast, lunch, and dinner. Unit Four's scheduled dinner was 5:50 PM through 6:15 PM. The kitchen tray line start times showed the kitchen start time (first tray), first unit delivery, and last unit delivery for breakfast, lunch, and dinner. For dinner, the kitchen start time (first tray) was scheduled at 4:40 PM, first unit delivery at 5:00 PM, and last unit delivery at 6:40 PM. During dining observations on 05/11/2026, residents in the dining area on the 4th floor began getting served at approximately 4:50 PM. There was no consistency with serving the dinner trays; tables were not served at the same time. Individuals were served and began eating, while other residents at the same table sat waiting for their food. During observations on 05/11/2026 on the 4th floor, residents were seated in the dining area between 4:20 PM and 5:03 PM. During observations on 05/11/2026 on the 4th floor, dinner was served to the residents seated in the dining area between 4:50 PM and 5:30 PM. Food carts were then brought up to the 4th floor to serve residents who eat in their rooms. During observations on 05/11/2026, Hallway A food carts were brought onto the 4th floor at 6:13 PM and staff began serving residents at 6:15 PM. During observations on 05/11/2026, Hallway B food carts were brought onto the 4th floor at 6:44 PM and staff began serving residents at 6:45 PM. During observations on 05/11/2026, Hallway C food carts were brought onto the 4th floor at 6:53 PM and staff began serving residents at 6:55 PM. During observations on 05/11/2026, Hallway D food carts were brought onto the 4th floor at 7:05 PM and staff began serving residents who were in their rooms at 7:06 PM. During dining observations on 05/11/2026 at 4:25 PM on the 4th floor, there were a minimum of ten staff present standing in the dining area, watching residents and no staff were observed assisting with meal service or expediting the delivery of trays. During an observation on 05/11/2026 at 5:05 PM on the 4th floor, Resident #192 was attempting to unwrap their sandwich and dining staff did not notice the resident needed assistance. Activities Recreation Aide #1 was leaving for the day and noticed the resident required assistance. Activities Recreation Aide #1 placed their belongings back in their office and returned to the dining area at 5:06 PM to assist Resident #192 with unwrapping their sandwich. During an interview on 05/11/2026 at 6:29 PM, Resident #350 stated the patio on the 2nd floor was open at the moment for residents to go sit and get fresh air, but they were unable to go since their dinner did not come up to the floor yet. Resident #350 stated breakfast and dinner were always served late. During an interview on 05/11/2026 at 7:10 PM, Dietary Aide #7 stated, We have just started a new way of serving and it has some things that need to be worked out, dinner should only take about 1 hour and 30 minutes to serve. Dietary Aide #7 stated, there are not enough people to work. During an interview on 05/11/2026 at 5:54 PM, Certified Nurse Aide #21 stated the snack pantry should always be stocked but has not been. Certified Nurse Aide #21 stated that normally after meals, a staff member from the kitchen would come up to the floors and restock. Certified Nurse Aide (continued on next page)

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F 0809 Level of Harm - Potential for minimal harm Residents Affected - Some	#21 also stated that staff members should not be standing around residents having personal conversations and that staff should be assisting residents with meals if they needed assistance. During an interview on 05/12/2026 at 10:46 AM, Food Service Staff #5 stated they were in charge of Dietary Food Service for the Front of the House. They stated the idea of the tray line in the main kitchen was to have meal carts come up at the same time as residents receiving meals in their floor dining rooms. Before the tray line, they would feed residents in the dining area. The idea now is to feed residents in their rooms earlier than those in the dining area. Food Service Staff #5 stated that Food Service Staff #9 oversees restocking snacks. Food Service Staff #9 should check inventory daily for each floor to see if snacks needed to be restocked. Snacks should be restocked between meals. If snacks were missing, a Dietary Aide would make Food Service Staff #5 aware, and they would go get the snacks for them. Some nurses used snacks during medication passes. During an interview on 05/12/2026 at 11:30 AM, Food Service Staff #9 stated they were in charge of Kitchen Production and that was considered the Back of the House. They stated they assist wherever needed and it was a lot to task. Food Service Staff #9 stated they needed everything to be on time, that they had all new staff and all were learning how to work a tray line. After the start of the tray line on 05/05/2026, Food Service Staff #9 decided to start the tray line a half hour earlier for every meal and stated kitchen staff were doing well for it being their first time. During an interview on 05/12/2026 at 5:12 PM, Food Service Director #3 stated they recently began working at the facility and their first day in the kitchen area was the day prior (05/11/2026). They further stated there was a new food system implemented on 05/05/2026 that they were grasping the system, which involved food preparation and tray line preparation within the main kitchen for residents who ate meals in their rooms, and a separate food preparation for residents who are eating on resident floor dining rooms. Food Service Director #3 stated they were observing and seeing what was going on, questioning efficiencies, and working with staff on the importance of proper labeling. They further stated yesterday (05/11/2026) was a huge struggle for dinner for the main kitchen tray line that prepared food for residents in their rooms to keep up. One tray line food station/step in the main kitchen was overwhelmed, so after the meal was completed, they reviewed what happened and addressed the issues. Food Service Director #3 stated they thought food service was a lot better today (05/12/2026). During an interview on 05/08/2026 at approximately 1:20 PM, Administrator #1 stated the facility had recently invested in purchasing non-electric, food transportation carts that would keep cold food cold and hot food hot from the main kitchen to the resident floors. They further stated there was a tray line system process that began that day (05/05/2026). Administrator #1 stated residents could either eat in their rooms or eat on their floor's dining room, called core. Food would be prepared and plated in the main kitchen tray line and placed into the transport carts for residents who ate in their rooms. For residents who chose to eat in the core, food would be prepared in the kitchen and brought to each resident floor kitchenettes for hot and cold holding. For residents seated in the dining room, food would be plated from the kitchenettes. 10 New York Code of Rules and Regulations 415.14(f)(1)(2)(3)(4)

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	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Van Duyn Center for Rehabilitation and Nursing	5075 West Seneca Turnpike Syracuse, NY 13215

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review, and interviews conducted during survey, the facility failed to properly store food items according to professional standards for food safety. Specifically, on 05/05/2026, the main kitchen had opened, undated and/or unlabeled food items with no use by date; areas were visibly dirty; one handwashing sink was not maintained; and on 05/12/2026, the automatic dishwasher final rinse temperature was observed at 178 degrees Fahrenheit and was documented as not meeting or exceeding final rinse temperature of 180 degrees Fahrenheit from 05/01/2026 through 05/11/2026. This was observed in the main kitchen and had the potential to negatively impact all residents, staff and visitors who consume facility-prepared food. Findings include:Record review of Vendor #2 Summary of Service dated 03/19/2026 revealed dishwasher machine service was initiated on 03/12/2026 when the facility reported the final rinse was not reaching 180 degrees Fahrenheit. It documented a service on 03/19/2026, where Vendor #2 found an issue with the booster and was submitting a repair estimate. ?Booster should have been replaced when the machine was. The final rinse gauge not working correctly. When I run the temperature gauge through the machine it is showing a plate temperature of 160 degrees which reaches sanitation point. Ordering new final rinse gauge. Install new temperature gauge and verify it is reading the temperature correctly. Currently due to the bad booster heater, the final rinse is only 100 degrees. Luckily the wash and rinse tanks are hot enough to sanitize the dishes. Recommend approving estimate to replace booster heater, water that hot with sanitizer is going to rust the machine.' Record review of Vendor #2 Service invoice dated 03/31/2026 documented service completed on 03/23/2026 and 03/31/2026 that included replacement of a motor, impeller, clamp, vacuum breaker, fuse, gasket, valve and valve solenoid. Technician notes documented that upon arrival to the service call, the facility stated the dishwasher machine was not turning on at all. Vendor #2 found the unit had power but was not doing anything. They determined a loose fuse holder on the relay board, a blown fuse. On 03/23/2026, the unit was only running on one wash pump and two pumps were down; the unit was also leaking out of all three vacuum breaks as well as constantly filling in wash tank. Vendor #2 attempted to drain unit and refill to test all solenoids but drains were clogged completely and unit would not drain. Advised customer it was not recommended to use until repairs were completed and infestation was remediated. On 03/31/2026, Vendor #2 installed all ordered parts and tested unit, and advised the facility the unit needed to be maintained better, with a large amount of trash in the unit causing issues. Record review of Vendor #2 Service invoice dated 03/31/2026 documented technician note of replacing the pump motors and drain bodies; unit was not being maintained with large amounts of debris in the machine. It further read, ?Dishes need to be scraped better. Customer needs to change water after every meal and clean wash and rinse arms daily. None of this is being done. Unit is currently operating correctly. Recommend cleaning.' Record review of May 2026 Dish Machine Temperature Record (High Temperature Machine) revealed: Final rinse temperature below 180 degrees Fahrenheit was logged for Breakfast service on 05/05/2026, 05/08/2026, 05/10/2026, and 05/11/2026. Lunch service on 05/08/2026 and 05/10/2026. Dinner service on 05/01/2026, 05/02/2026, 05/05/2026, 05/07/2026, 05/08/2026, 05/09/2026, and 05/10/2026. During observations on 05/05/2026 between 6:25 AM and 7:17 AM, the following was observed in the Main Kitchen: Walk-in refrigerator (adjacent to dry storage room) contained open, undated items, including one tub of mayonnaise, one tub of Italian dressing, and a sheet rack of bagged liquid eggs (no label). Walk-in freezer (adjacent to dry storage room) contained open, undated items including one package of meat (no label), one box of cucumbers, and one package of sausage patties. Three-compartment sink (adjacent to dry storage room) contained soapy water and food debris. A rag was wrapped tightly around the leftmost sink faucet. Floor was visibly dirty including around three-compartment sink (adjacent to dry storage room) with two shop vacuums present. Two chemical bottles containing liquid sat on a dirty, three-shelf tan cart. Metal preparation (continued on next page)

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	335184	A. Building B. Wing	05/13/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	cabinet, missing its door, was dirty on the shelves and had items arranged haphazardly. Facility-designated employee handwashing sink located adjacent to the automatic dishwasher had part of an eye washing station attachment to it but did not function. Noted with red grime and a spoon in the sink. During an observation on 05/12/2026 at 5:34 PM in the presence of Food Service Director #3, the automatic dishwasher located within the main kitchen was in use by an employee. The final rinse temperature gauge read 178 degrees Fahrenheit. During an interview on 05/05/2026 at 6:35 AM, Food Service Director #2 stated they were in the role for the last two weeks as an interim because Food Service Director #1 left unexpectedly. During an interview on 05/05/2026 at 7:10 AM, Food Service Director #2 acknowledged the findings and stated that opened items should be dated and labeled. Items that had been opened and not properly labeled or dated would be voluntarily discarded and they would remind the staff as they knew better. During an interview on 05/05/2026 at 7:10 AM, Food Service Director #2 stated they would put a ticket into maintenance or call a vendor if there was something wrong with a piece of equipment. During an interview on 05/07/2026 at approximately 5:35 PM, Administrator #1 stated they had recently invested in repairing the automatic dishwasher when it was down for a short time earlier in the year and would provide vendor records. Administrator #1 stated Food Service Director #2 was serving in an interim role, and that Food Service Director #3 completed onboarding and would be starting on 05/11/2026. During an interview on 05/12/2026 at 5:12 PM, Food Service Director #3 stated they recently began working at the facility and their first day in the kitchen area was the day prior (05/11/2026). They further stated they were observing and seeing what was going on, questioning efficiencies, and working with staff on the importance of proper labeling. During an interview on 05/12/2026 at 10:46 AM, Food Service Staff #5 stated a dietary aide is assigned to unload finished dishware, scrape, sort the silverware, and clean the cart. They stated one of the main tasks for the morning supervisor is to check the automatic dishwasher and before it is used, it is checked to make sure hot water temperatures are where they need to be. If there is a problem, they would report it to maintenance, place a request or call Director of Plant and Operations #1. They further stated that the automatic dishwasher had been down for two to three weeks, and they switched to hand washing until four or five items on the automatic dishwasher was fixed. During an interview on 05/12/2026 at 5:38 PM, Food Service Director #3 stated from what they were seeing, dirty dishes came down from the units and were going through the automatic dishwasher conveyor machine. Supervisors oversaw cooks and the dishwasher, and the final dishwasher temperature should have been 180 degrees Fahrenheit. Food Service Director #3 further stated that the expectation was if something is wrong [if the final temperature is not reaching 180 degrees Fahrenheit], they should let a supervisor know the machine was not getting to temperature. Food Service Director #3 stated they would look into it. During an interview on 05/12/2026 at 5:51 PM, Director of Plant and Operations #1 stated they oversaw security, maintenance and plant operations for all mechanical aspects of the building. They stated domestic hot water was used for the automatic dishwashing machine along with a booster heater. There was a capital investment in the dishwashing machine where they replaced valves, a steam leak repaired, heat coil to dry dishes. Director of Plant and Operations #1 stated they just installed a new final rinse gauge and the lowest temperature they had seen on the final rinse cycle was 177 degrees Fahrenheit. When the surveyor noted the observed final rinse temperature on 05/12/2026 to be 178 degrees Fahrenheit, Director of Plant and Operations #1 stated they would dial up the temperature from the system. 10 New York Codes, Rules, and Regulations 415.14(h)