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	04/18/2025

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 0550 Level of Harm - Actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46276 48446 49448 Based on observations, record review, and interviews during the recertification and abbreviated (NY00374160) surveys conducted 4/6/2025 - 4/18/2025, the facility did not ensure residents were treated with respect and dignity in a manner and in an environment that promotes maintenance or enhancement of quality of life, recognizing each resident's individuality for two (2) of three (3) residents (Residents #170 and #335) reviewed. Specifically, Residents #170 and #335 were continent (able to control bladder and bowel), placed in incontinence briefs, and were told by staff to urinate/defecate in the briefs instead of using the toilet and/or bedpan. This resulted in psychosocial harm to Residents #170 and #335 that was not Immediate Jeopardy. Findings include: The facility policy Dignity and Respect, last reviewed 8/2023 documented residents had the right to be treated with dignity, respect, and consideration at all times. Staff should ensure residents were treated as individuals and encourage them to participate in programs and services of their choice and protect them from any kind of harsh and abusive treatment. 1) Resident #335 had diagnoses including difficulty walking, need for assistance with personal care, and had menstrual cycles. The 2/25/2025 Minimum Data Set assessment documented the resident had moderate cognitive impairment, toilet transfer was not attempted due to medical condition or safety concerns, was dependent for toileting hygiene, and did not reject care. The 3/27/2025 Physical Therapist #42 discharge summary documented discharge recommendations of moderate assistance of one (1) for transfers with a stand pivot technique. The undated care instructions documented the resident was dependent on one-person assist for toileting hygiene and required substantial/maximum assist of two (2) staff for toilet transfers; incontinent of bladder, bedpan, assist with changing briefs, and occasionally incontinent of bowel. The April 2025 certified nurse aide Activities of Daily Living Toileting Use record documented the resident was incontinent and toilet transfer was not attempted at the following times: (continued on next page)

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

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	04/18/2025

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 0550 Level of Harm - Actual harm Residents Affected - Some	- On 4/6/2025 once on the day shift and once on the night shift. - On 4/7/2025 once on day shift, once on evening shift, and twice on night shift. - On 4/8/2025 once on day shift and once on evening shift. - On 4/9/2025 once on day shift, once on evening shift, and twice on night shift - On 4/10/2025 once on day shift and once on evening shift. - On 4/11/2025 once on day shift, once on evening shift and once on night shift. - On 4/12/2025 twice on day shift, once on evening shift and once on night shift. - On 4/13/2025 - 4/15/2025 once on day shift, once on evening shift and once on night shift Resident #335 was observed and interviewed: - On 4/6/2025 at 2:52 PM, they were in their room sitting up in their wheelchair wearing a hospital gown. They stated when they asked to go to the bathroom, the certified nurse aides would not let them and told them to just go in their incontinence brief. When they told the certified nurse aides they could use the toilet instead of an incontinence brief, the certified nurse aides got mad and wanted to argue. The resident was currently on their menstrual cycle, and they were told they had to have their brief changed in the bed so once they were up for the day, they were not provided with toileting assistance until they wanted to go back to bed. - On 4/8/2025 at 9:19 AM, they were lying in bed in a hospital gown. They stated the certified nurse aides just told them to go in their brief and the next shift would change them. It made them want to cry that they had to soil themself, but it was even worse because it was during their menstrual cycle. The last time they were assisted with a brief change was last night before bed. At 11:50 AM Certified Nurse Aide #43 entered the resident's room with a razor, washcloths, and towels. At 12:17 PM, the resident was up in their wheelchair in the room in a hospital gown. The resident stated Certified Nurse Aide #43 had just changed their incontinence brief, cleaned them, and transferred them from the bed into their wheelchair by stand and pivot. This was the first time their brief was changed since before bed last night. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0550 Level of Harm - Actual harm Residents Affected - Some	- On 4/9/2025 at 9:37AM, the resident had completed breakfast and was lying in bed in a hospital gown. They stated Certified Nurse Aide #45 changed them around 11:00 PM last night. Their incontinence brief was currently wet and had not been changed since last night. Certified Nurse Aide #43 (the current day certified nurse aide) told them they were not allowed to utilize the bathroom and told them to go in the brief. They got frustrated because they knew when they needed to go to the bathroom and if they put their call bell on, staff just turned the light off and never came. They could not hold it anymore and had to soil the brief. Their menstrual cycle ended yesterday, and they did not like being dirty and it smelled; it was embarrassing. They ate breakfast today and dinner last night with a wet brief. If they told the certified nurse aides they wanted their brief changed before their meal, the certified nurse aides got mad and told them they had to wait. The resident liked going to visit their daughter because their daughter helped them on to the toilet and assisted with wiping and they did not have to use the incontinence brief. The worst was when they had to have a bowel movement; it was embarrassing, it made them feel dirty, and it smelled. - On 4/15/2025 at 10:58 AM, they were lying in bed in a hospital gown. The resident stated they had a new brief placed around midnight last night and had not been provided with any toileting assistance since then. During an interview on 4/15/2025 at 12:12 PM, Certified Nurse Aide #43 stated they always provided incontinence care to the resident before lunch and once the resident was up in their wheelchair, they were good for the shift. The resident was incontinent because they could not walk, and therapy had not cleared them to utilize the bathroom. They were aware the resident wanted to use the bathroom, but they had not mentioned anything to anyone to get them a therapy evaluation. They stated if a resident soiled themself when they could be toileted, it was not appropriate and would not be comfortable. They would not want to be around other people or would not like to eat their meals like that. It was a dignity issue and could make the resident feel like nobody cared. It would not be a good feeling and would be sad and embarrassing. They stated the resident's legs were weak, and they were not comfortable putting them on the toilet and would need assistance of another person to place the resident on the toilet. During an interview on 4/16/2025 at 11:30 AM, the Director of Rehabilitation stated the resident was discharged from physical therapy on 3/27/2025 and their transfer status was moderate assistance of one (1) with a stand and pivot, so there was no reason why they should not be able to use a toilet. The care plan documented toileting was not attempted due to a medical condition/ safety concern and was never updated. The resident was not reassessed for toileting after their transfer status improved but they should have been. It was not good the resident was soiling themself in a brief because the certified nurse aides told them they could not use the bathroom. This was a quality-of-life issue. Nursing should have put in a referral; physical therapy should have communicated with occupational therapy so the toileting status could be updated. During an interview on 4/16/2025 at 2:37 PM, Certified Nurse Aide #45 stated when they started their night shift, the resident was already in bed. Sometimes they were wet and sometimes not. The resident was in their right mind, could ring for help, and did not like being soiled. The resident had reported to them they were left soiled all day until they wanted to go to bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0550 Level of Harm - Actual harm Residents Affected - Some	During an interview on 4/17/2025 at 9:30 AM, Certified Nurse Aide #44 stated Resident #335 could verbalize when they needed to use the restroom and was a stand and pivot of one (1) assist for transfers. When they came in for their evening shift, the resident was in their wheelchair, and they assisted them into the bed during their shift. The bathroom was small, but they did not know why the resident did not have a bedside commode. The resident told them it made them sad the certified nurse aides did not listen to them and they hated sitting in their own feces. Going to the bathroom was a basic human right, this was their home, and the resident should be able to do what they were able to do. It was not right they were being told to just use the brief and wait for hours to be changed. During an interview on 4/17/2024 at 10:10 AM, Licensed Practical Nurse Assistant Unit Manager #46 stated Resident #335 would call for the bedpan. The resident was incontinent at times but was alert and oriented and able to make their needs known. The resident should not be told to soil themselves. It was not appropriate, and it made the resident feel horrible. Even if the resident did not ring their call bell, the certified nurse aides should be checking in every 2-3 hours to ask if the resident needed to use the bathroom. During an interview on 4/17/2025 at 11:14 AM, Assistant Director of Nursing #47 stated Resident #335 was incontinent at times, but they had known the resident to use a bedpan in the past. The resident transferred with a stand and pivot and occupational therapy needed to evaluate the resident for use of the bathroom. During an interview on 4/18/2025 at 11:00 AM, Nurse Practitioner #48 stated Resident #335 was alert and oriented and should not be told to utilize an incontinence brief, as it was a dignity issue. This would be frustrating and upsetting for the resident. It was also a dignity issue to eat their meals with a soiled brief/smell of waste, and the resident should also have regular care for their menses. During an interview on 4/18/2025 at 11:28 AM, the Medical Director stated a continent person should never be told to use an incontinence brief. The facility had a lack of assistance, the staff told the residents just to urinate in their incontinence briefs and put on their call bell, and maybe three (3) hours later someone would come back to change them. All residents should be treated with respect, and this treatment would definitely affect mental health and negatively affect psychosocial well-being. 2) Resident #170 had diagnoses including anxiety disorder, pain, and morbid obesity. The 1/21/2025 Minimum Data Set assessment documented the resident had intact cognition, did not reject care, was occasionally incontinent of urine, frequently incontinent of bowel, and was dependent on staff for toileting. The Comprehensive Care Plan initiated 2/9/2024 and revised 4/14/2025 documented the resident required assistance with self-care and toileting related to impaired mobility. The resident was continent of bladder and bowel, used the bedpan for toileting, was unable to use the toilet, used a lifting device for transferring, and was dependent on staff for toileting. The resident care instructions documented Resident #170 was continent of bladder and bowel, was dependent on one staff for toileting, and used the bedpan. Resident #170 was observed and interviewed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0550 Level of Harm - Actual harm Residents Affected - Some	- On 4/6/2025 at 12:41 PM, Resident #170 was sitting in the dining room. They stated certified nurse aides made them wear a brief even though they were continent of urine. Two (2) incontinence briefs were put on in the morning and certified nurse aides told them to urinate in the briefs. The resident preferred to go back to bed and use the bedpan, however staff told them if they went back to bed, they had to stay there for the remainder of the day and would not be able to attend activities they enjoyed. At times they were so soaked with urine there was a puddle underneath their chair, and it was embarrassing. Their lift pad that was underneath them was always wet and smelled of urine. They could not send it to laundry because it never came back and then they were stuck in bed. They did not get changed until after 8:00 PM when they were put to bed for the day. They did not want to be in incontinence briefs, but did not want to be isolated to their room because they were very social. They felt worthless and like they did not matter to staff. They feared retaliation if they refused to wear an incontinence brief. - On 4/7/2025 at 8:07 AM, resident was in the dining room. There was a strong smell of urine coming from the resident. They stated they asked their certified nurse aide for a new lift pad that was underneath them but there was not one available to use so a certified nurse aide sprayed the pad. They wanted their shower last Wednesday (4/2/2025), but did not get it as they required two (2) staff for showering and there was only one (1) staff available. They stated they were wearing an incontinence brief for staff convenience as staff did not want to get them in and out of bed to use the bedpan. They preferred to wear underwear and not being able to wear underwear and having to urinate in the incontinence brief made them feel bad and like they were not human. - On 4/8/2025 at 9:21 AM, resident was wearing a gown in bed. Their hair was greasy, and they had their call bell on. Licensed Practical Nurse #11 entered the room with medication for the resident. An unidentified certified nurse aide called into the room and told Licensed Practical Nurse #11 to cut the light, we are in the dining room, and the nurse turned the call bell light off and left the room without asking the resident what they needed. There was a strong smell of urine from the room that became stronger closer to the lift pad. The lift pad smelled of urine and had a dark outline on the pad where it had been wet and then dried. The resident stated they needed the bedpan and was upset staff left without putting them on the bedpan or even asking why the call bell was on. At 12:59 PM, the resident stated Certified Nurse Aide #124 put them on the bedpan and then put an incontinence brief on them before getting them up for the day. They stated the lift pad underneath them smelled of urine and they called central supply themself yesterday and today for a new pad and was told there were none available. They stated they were wearing two (2) incontinence briefs and did not want to be wearing incontinence briefs or have a lift pad that smelled of urine. They stated wetting themself was embarrassing. During an interview on 4/9/2025 at 12:43 PM, Certified Nurse Aide #124 stated Resident #170 had a routine of asking for the bedpan as soon as they woke up, usually around 9:00 AM. After they were done with the bedpan, staff washed them up and put on powder and incontinence briefs. Utilizing a lifting device, they and another staff member transferred the resident to the chair. They stated they were assigned to Resident #170 on 4/8/2025, but were unable to get the resident on the bedpan because they were assigned to the dining room during mealtimes. Staff covering the unit should have answered the resident's call bell and put them on the bedpan. The resident was continent, but they placed an incontinence brief on them because the resident did not have underwear. If the resident had underwear, they would not put an incontinence brief on the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0550 Level of Harm - Actual harm Residents Affected - Some	During an observation on 4/9/2025 at 12:34 PM, Resident #170 was in the dining room with a strong smell of urine coming from them. During an observation and interview on 4/10/2025 at 1:09 PM, Resident #170 was in an incontinence brief in their wheelchair with a strong smell of urine coming from them. They stated they were in a dry incontinence brief and did not want to be in the brief because it was embarrassing and degrading to have to wet themself. Their lifting pad underneath them smelled because it was urine soaked and they wanted a new pad. During an observation and interviews on 4/15/2025 9:37 AM, Resident #170 was observed being transferred to their wheelchair and was wearing an incontinence brief. Certified Nurse Aide #124 stated although the resident was continent, they put an incontinence brief on them because the resident would need the bedpan every hour in the morning. Certified Nurse Aide #124 stated months ago, the resident asked the provider to change the time of their water pill to the evening time as they were in bed, and it was easier for staff to get them on the bedpan. They did not want the water pill in the morning because staff made them urinate in the incontinence briefs and they went so much there were puddles underneath them. Certified Nurse Aide #124 stated they also put an incontinence brief on the resident to keep the lifting pad dry, so it did not smell. Lifting pads were washed by laundry. They stated last week the lifting pad smelled so bad they went to laundry, and they did not have a clean lifting pad, so the resident continued to use the lifting pad that smelled of urine. The resident's lifting pad was sent to laundry 4/10/2025 or 4/11/2025 and there was not an available lifting pad when they worked on 4/12/2025 so the resident remained in bed. Certified Nurse Aide #124 stated if a continent resident was wet or if a lifting pad was urine-soaked and smelled it could make the resident embarrassed and feel bad. At 10:28 AM, Resident #170 stated they asked to get out of bed on 4/13/2025 and were told there were no lifting pads available to get them out of bed. They called Assistant Activities Director #125, as that was the only person that helped them. They also told Social Worker #121 about being forced to wear incontinence briefs and nothing was done. During an interview on 4/17/2025 at 10:20 AM, Certified Nurse Aide #127 stated the resident was continent of urine and on their shift (evenings), they asked for the bedpan. The resident was wet most days when they put them back to bed and they had seen them in their wheelchair with a puddle of urine underneath. If a resident was told to wear a brief and was continent it could be uncomfortable and embarrassing. During an interview on 4/17/2025 at 11:33 AM, Social Worker #121 stated residents should not be told to wear an incontinence brief for staff convenience. If a resident sat in a wet incontinence brief all day it could make them feel terrible and a soiled lifting pad could make them feel dirty. During an interview on 4/17/2025 at 11:56 AM, Licensed Practical Nurse #21 stated Resident #170 was continent of urine and should not be put in an incontinence brief because it could make them feel badly. They were unsure if the resident was toileted during the day, and they should be. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0550 Level of Harm - Actual harm Residents Affected - Some	During an interview on 4/17/2025 at 12:12 PM, Licensed Practical Nurse Unit Manager # 22 stated if a resident required a lifting pad for transferring and there was not one available, the resident would be confined to bed and could feel isolated. If the pad was soiled and smelled of urine it could make the resident feel horrible. Continent residents should not be wearing incontinence briefs unless it was their preference because it could be a dignity issue and was embarrassing. Residents who were able to use the bedpan should be put back to bed for toileting and returned to their wheelchair. When a resident was wet, they should be changed and not left in the wet incontinentce brief. Resident #170 was continent, should not be wearing an incontinence brief, and if they did not have underwear, the social worker should be notified to get some. During an interview on 4/17/2025 at 2:22 PM, Nurse Practitioner #23 stated continent residents should be either taken to the bathroom or placed on a bedpan. No resident should be left in a wet incontinence brief as they could get a urinary tract infection or skin breakdown. More importantly, research showed being left in a wet incontinence brief had a huge negative impact on mental health. Resident #170 was continent and should not be in an incontinence brief. Putting Resident #170 in an incontinence brief and having them wet themself and/or not having a clean lifting pad could cause psychosocial harm. 10 NYCRR 415.5(d)(1)(i)

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	04/18/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48895 Based on observations, interviews, and record review during the recertification survey conducted 4/6/2025-4/18/2025, the facility did not ensure the interdisciplinary team determined a resident's ability to appropriately self-administer medications for one (1) of one (1) resident (Resident #50) reviewed. Specifically, Resident #50 had medications in their room they stated they could self-administer. Findings include: The facility policy, Self-Administration of Medications, revised 8/2020, documented if the resident desired to self-administer medications, the interdisciplinary team conducted an assessment of the resident's cognitive, physical, and visual ability to carry out this responsibility during the care planning process. Resident #50 had diagnoses including deafness, pain, and atherosclerotic heart disease (plaque buildup in the arteries). The 3/4/2025 Minimum Data Set assessment documented the resident was cognitively intact and independent with activities of daily living. The Comprehensive Care Plan revised 12/30/2024 documented the resident's cognition, psychosocial, mood state, and behavior care plan. Interventions included to encourage continued establishment of goals and participation in his plan of care as able. There was no documented evidence of the resident's ability to self-administer medications. The following medications were ordered for Resident #50: - on 4/5/2024, by Nurse Practitioner #48 aspirin 81 milligrams and atorvastatin (cholesterol medication) 20 milligrams every day - on 2/9/2025, by Nurse Practitioner #23 acetaminophen (pain medication) 1,000 milligrams twice daily. During an interview on 4/9/2025 at 2:20 PM, Resident #50 communicated via in-person certified American Sign Language Interpreter #53. Resident #50 stated staff just came into their room with no introductions or acknowledgement. They came into the resident's room dropped off the medication cup on their table and left. They stated they knew what medications they took; they had 3 in the morning and 3 at night. They stated the facility claimed they refused their medications, but that was because the nurse added medications to the medication cup, did not explain what they were, and just expected them to take what was given without question. During an observation on 4/12/2025 at 9:26 AM, Resident #50 took their medications from the medication cup without a nurse present. Licensed Practical Nurse #126 was at the opposite end of the hall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/13/2025 at 9:25 AM, Resident #50 had four (4) pills in a medication cup on their bedside table. The resident attempted to communicate the medications with gestures but pointed to the medication poster on the floor. The pills matched the medications for acetaminophen, atorvastatin, and aspirin. At 9:59 AM and 10:13 AM, the 4 pills remained in the medication cup at the resident's bedside. During an interview on 4/18/2025 at 11:11 AM, Licensed Practical Nurse Unit Manager #22 stated there were no residents with medication self-administration orders. The nurses should not leave medications at the bedside, they should stay and observe them being taken. Resident #50 would be a good candidate for self-administration after preparation. The nurse could prepare the medications in the cup, and they would take them when they wanted with breakfast. The resident knew what routine medications they took and when to take them. They had residents that did that in the past, and there was an assessment that could be completed. 10 NYCRR 415.3 (f)(1)(vi)

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	04/18/2025

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 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 48446 48895 Based on observations, record review, and interviews during the extended recertification and abbreviated (NY00376311) surveys conducted 4/6/2025 - 4/18/2025, the facility failed to ensure resident's right to choose activities and health care services consistent with their interests, assessments, and plan of care and the right to participate in social and community activities for two (2) of three (3) residents (Resident #50 and #162) reviewed. Specifically, Residents #50 and #162 were Deaf and were not provided their preferred method of communication and thus were unable to communicate their needs and preferences to staff, socialize with other residents, or participate in meaningful activities. This resulted in actual psychosocial harm to Resident #50 that was Immediate Jeopardy and Substandard Quality of Care. Findings include: The facility policy Language Assistance, last reviewed 7/2021, documented each resident's language access needs would be reviewed and monitored during their comprehensive care plan review and conference. Language assistance would be provided through use of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations providing interpretation or translation services, communication boards, or technology and telephonic interpretation services. If an internal staff member who was fluent in the needed language was not available, Language Line or other local agencies would be contracted for assistance. Family members or friends of a Limited English Proficiency resident would not be used as an interpreter unless specifically requested by the resident and after they understood that an offer of an interpreter at no charge to the resident had been made by the facility. The facility policy Resident Rights, reviewed 8/2023 documented residents had the right to choose activities, schedule, and health care consistent with their interests and plan of care. The facility must promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of their individuality. 1) Resident #50 had diagnoses including deafness, non-speaking and anxiety disorder. The 3/4/2025 Minimum Data Set assessment documented the resident was cognitively intact, had absence of useful hearing and spoken words, their preferred language was sign language, and they sometimes felt lonely or isolated from those around them. The answer to the question How often do you need to have someone help you when you read instructions, pamphlets, and other written material from your doctor or pharmacy? was blank. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Comprehensive Care Plan revised 12/14/2024 documented the resident had highly impaired hearing, absence of useful hearing, did not have the ability to produce speech, was able to understand American Sign Language, and had the ability to read and write. Interventions included anticipate needs due to communication barrier, use simple language and yes/no questions when communicating, ensure access to writing material/white board, utilize picture board for simple American Sign Language communication if requested, writing equipment was available at bedside/table, and make attempts to understand the resident's frustrations, when necessary. The 4/5/2024 Speech Language Pathologist #34 progress note recommended for all communication staff/family continued to utilize live American Sign Language interpreting service via tablet which could be obtained in Administration. Should staff be unable to access live American Sign Language services, it was recommended to utilize written language via whiteboard to ensure Resident #50 was able to effectively communicate wants/needs. Invoices provided by the facility documented interpreting services were contracted twice for Resident #50 on 7/12/2024 for two (2) hours, and on 2/21/2025 for two (2) hours. During an interview on 4/7/2025 at 12:42 PM, Resident #50 communicated via simple word document and gestures. They wanted a tablet to help with interpretation for everyday communication and socialization. The resident provided the surveyor with contact information for interpretation services and asked for them to be contacted to help with communication. During a telephone interview on 4/8/2025 at 11:13 AM, Deaf Services Manager #18 (from local advocacy agency for the Deaf) communicated the facility had a tablet they were supposed to regularly use for interpretation for Resident #50. During an interview on 4/8/2025 at 9:12 PM, Certified Nurse Aide #4 stated Resident #50 communicated with gestures or whiteboard and marker. Certified Nurse Aide #4 took the surveyor to the resident's room to show the whiteboard and Resident #50 began to use signing to communicate. Certified Nurse Aide #4 stated the resident had a tablet for interpreting services but did not use it. The Certified Nurse Aide stated they did not know how to use the tablet. It was important to know how to communicate with the resident to know their needs. Certified Nurse Aide #4 interrupted after overhearing the interview and stated the only means of communication for Resident #50 was the whiteboard and the resident did not use the tablet for communication. During an interview on 4/8/2025 at 11:08 PM, Certified Nurse Aide #19 stated the resident's care instructions documented to use a writing board for communication. The facility had used video services for the residents during the COVID-19 pandemic, but it was not specific for Resident #50. They did not have a tablet on the unit for communication and the Supervisor would have to be called to use that. They did not know how to get video interpretation for Resident #50. They should use the resident's preferred method of communication because it was familiar to them, and it would let staff know what the resident needed. During an interview on 4/8/2025 at 11:08 PM, Certified Nurse Aide #20 stated Resident #50 wrote on a whiteboard for the staff. The resident did not speak and was Deaf. They did not have interpreting services on the overnight shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/9/2025 at 9:42 AM, Licensed Practical Nurse #21 stated if a resident's language was other than English, they could not see that information in the computer. Resident #50 used a whiteboard for communication. If the resident needed something they came out of their room carrying their whiteboard. It was important for Resident #50 to be able to communicate with them and feel comfortable asking for things and have open communication. During an interview on 4/9/2025 at 2:20 PM, Resident #50 communicated via in-person certified American Sign Language Interpreter #53 (from local advocacy agency for the Deaf). The resident communicated they felt isolated in the facility because the staff only used a whiteboard to communicate with them. Staff did not acknowledge them when they came to their room because they were Deaf. Their preferred method of communication was American Sign Language, either with use of staff that used American Sign Language, an in person interpreter, or video phone interpretation. English was not their primary language, and they were not comfortable writing in English. They stated they were isolated on the 4th floor, because they could not explain their needs in detail. The video relay phone interpreter would allow them to communicate with Deaf peers outside the facility as well as people in the facility. If the activity programs had an interpreter they would attend, but interpretation was not provided. When medication changes were made, such as adding a new medication, or a change in their regular medication, it was not explained to them. They were expected to take whatever was given to them. There was one point they refused to take their medications because the facility added two (2) pills, and no one explained what they were. The resident stated Deaf Services Manager #18 came to visit, and the facility explained the medication was because other residents in the building had the flu and it was ordered for everyone. The resident stated they lived a very structured life at home, and the routine kept them comfortable. They ate lunch at noon, and the lunch trays at the facility were not delivered until 2:00 PM or 2:30 PM, which caused a stomachache from hunger. They stated they were suffering in the facility, because they could not communicate when they were hungry, did not feel good, or if they had specific needs. They stated they were just alone and that no one cared about them. During an observation on 4/10/2025 at 11:23 AM, Resident #50 walked out of their room and down the hall to the dining area. They passed two (2) unidentified staff members, went to the kitchenette, got coffee and ice from the machine, and there was no staff interaction. The resident walked back towards their room, past the staff at the nurse's station, and no staff interacted with them. An unidentified staff crossed in front of the resident with no interaction. During an interview on 4/10/2025 at 11:30 AM, Licensed Practical Nurse Unit Manager #22 stated the expectation for residents that spoke a language other than English was to use their primary language. The resident's preference for communication should be honored. They stated Resident #50's primary language was English. If they wanted to use a tablet for communication, they should be allowed, and Activities had a tablet that could be used. Use of the whiteboard for communication was done by trial and error. The facility had not set up interpreting services for Resident #50. Resident #50 was a loner and preferred to stay in their room. When there were facility-wide or floor-wide activities there was no interpreter present. The resident should not have to ask for interpreting services to participate in activities. They stated they did not ask the resident if they would attend activities if an interpreter were present. There were three (3) residents on the 4th floor that used American Sign Language. The medical providers did not use an interpreter when they visited the residents. The resident did not have means of communication with friends outside the facility and was not asked if they wanted to communicate with people outside the facility. The resident should not have to ask to communicate with people. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 4/10/2025 at 12:55 PM, Nurse Practitioner #23 stated the expectation for residents with English as a second language was to use the language line tablet from the business office. The resident's communication preferences should be honored. It was important to allow the resident to speak openly and freely. Resident #50's primary language was English, and they preferred to use the whiteboard for communication. They were not sure how the determination was made the whiteboard was the preferred method. They ensured understanding with teach back methods (return demonstration) and reinforcements of writing on the whiteboard and the resident would respond. If medical consent was needed, they would ensure the interpreting service was contacted first, and the interpreting service was aware of all medication changes for the resident. During a telephone interview on 4/10/2025 at 1:03 PM, the Medical Director stated staff could be used as interpreters and translators, but if that was not available, they could get additional translators. The resident's communication preference should be honored. It was important to get good, detailed information from the resident. The resident needed to be able to explain their concerns freely. During an interview on 4/10/2025 at 2:59 PM American Sign Language Interpreter #53 stated they knew the resident well. The resident had very limited English proficiency and the best access for the resident was live American Sign Language interpretation. If no interpreter was available, a tablet with a video relay interpreter was the best choice. The resident was unable to reach out to Deaf friends in the community or communicate with anyone from the facility. The video relay interpreter was a free service. During an interview on 4/10/2025 at 2:30 PM, the Administrator stated they expected to accommodate residents with English as a second language. They used the language line and picture boards provided by speech therapy. A resident's communication preference should be honored. The language line was easily accessible and accommodating. They stated they had never attempted to communicate with Resident #50. The resident's primary language was American Sign Language and the preferred method of communication for the resident was the whiteboard. They did not know how that was determined. They were not sure if the provider used an interpreter during medical exams, and did not know how they ensured informed consent. The facility did not set up interpreting services to ensure effective communication. They stated the Deaf advocacy organization should have advocated for the resident. They stated they did not feel the resident was socially isolated, even though they did not provide means of communication or means to participate in activities or meaningful discussion. During an interview on 4/10/2025 at 2:48 PM, the Assistant Administrator stated Resident #50's primary language was American Sign Language, and they used a whiteboard for communication. They did not know how the whiteboard was determined to be the resident's preferred method of communication, but that was what the facility used for all residents that could read and write. The providers in the facility did not use an interpreter for every visit, but did have the whiteboard available. They did not use an interpreter to get a better understanding of the resident's needs. Informed consent was done with the whiteboard. When the facility held activities, they did not provide an interpreter, and the resident should not have to ask for interpreting service for activities that were provided to all residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2) Resident #162 had diagnoses including degenerative disorder of the retina (part of the eye) and stroke. The 1/20/2025 Minimum Data Set assessment documented the resident had moderately impaired cognition, had absence of useful hearing and spoken words, and had highly impaired vision. Their preferred language was sign language; and they needed or wanted an interpreter to communicate with a doctor or health care staff. The Comprehensive Care Plan, revised on 4/10/2025, documented the resident had a communication deficit related to absence of useful hearing, was able to speak and communicate their wants or needs, had vision deficits, and had cognitive impairment related to stroke which affected their ability to understand despite using communication intervention. The 3/21/2025 interventions included to provide and encourage use of communication board, ensure writing equipment was available, and encourage use of and utilize live American Sign Language interpreter services, tablet was available in Administration. The 4/10/2025 interventions included to arrange in-person interpreter services, speech therapy as needed and utilize picture board for simple American Sign Language communication. The 2/1/2024 Speech Language Pathologist #34 progress note documented Resident #162 was provided with basic important medical signs on their wall, in their primary language, American Sign Language. All staff were encouraged to use American Sign Language when communicating with the resident. The 2/2/2024 Social Worker #33 progress note documented Resident #162 was Deaf and communicated through American Sign Language. The resident was able to answer 2-3 word questions with a white board; however, their handwriting was not legible. Speech therapy staff would provide the resident with a white board for short term use. The 3/5/2024 Speech Language Pathologist #34 progress note documented they recommended the facility pursue live, in-person American Sign Language interpreting services, which was also recommended by the resident's Case Manager and an American Sign Language speaking peer. Pending interpreting service, the recommendation was for staff to continue communicating with the resident through 1-3 large written words via whiteboard. The 4/9/2024 Social Worker #35 progress note documented Resident #162's third party social worker had concerns the resident's wishes were not being heard due to the language barrier. The 6/12/2024 Social Worker #36 progress note documented Resident #162 could not hear and had very bad vision, therefore, could not hear staff during assessments nor see when they wrote a question on the white board. The cognition assessment was done by staff. Invoices provided by the facility documented interpreting services were contracted for Resident #162 twice, on 4/5/2024 for 2 hours, and 6/26/2024 for 1 hour. There were no invoices provided for interpreting services in 2025. The 4/8/2025 Speech Language Pathologist #34 Therapy Progress Report documented Resident #162 had precautions listed for low vision, Deaf, and American Sign Language as the primary modality of communication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on 4/15/2025 at 10:37 AM, Resident #162 was in the hallway with the Assistant Administrator and an in-person interpreter. Resident #162 communicated they needed their ears cleaned, they wanted to go home soon to their own family, and that they knew another person in the building that signed well. During a telephone interview on 4/15/2025 at 11:33 AM, Resident #162's family stated the resident's preferred method of communication was American Sign Language. They could use a tablet for video interpretation, and the facility used one in the beginning, but not anymore. If the resident had concerns, they could not alert staff to their needs. They were told by the former social worker the facility was working on getting a full-time interpreter for the facility. The facility had not attempted to use the tablet or interpreter service since the resident's re-admission after surgery in 3/2025. The facility would call the family when they did not understand what the resident needed, but not everyone in the family used American Sign Language. The family depended on the facility to ensure the resident's needs were met. During an interview on 4/17/2025 at 1:26 PM, Certified Nurse Aide #38 stated Resident #162 had a tablet of their own, it was in the resident's closet. They always had it, but they were not sure if staff knew how to use it. During an interview on 4/17/2025 at 1:27 PM, [NAME] Clerk #39 stated Resident #162 preferred to use the tablet for interpreting or signing. They did not have a tablet for interpreting before this week; it was not available to them. The staff would write or Google signs to help understand. They were taught about the language line but had not used it before this week. During an interview on 4/17/2025 at 1:32 PM, Licensed Practical Nurse Assistant Unit Manager #40 stated Resident #162 did not own a tablet and was provided a tablet by the facility this week. The tablet was not readily available to the resident before then. The resident could see with their glasses on or off, but it was more beneficial when they wore them. Their right eye was much stronger and if staff used the right side the resident could communicate. 10 NYCRR 415.5(b)(1-3) ********** The facility was notified of the Immediate Jeopardy on 4/11/2025 at 12:42 PM. The Immediate Jeopardy was removed on 4/16/2025 at 10:50 AM prior to the completion of the survey. The facility implemented the following to remove the immediacy: - Initial plan of immediacy was approved on 4/11/2025 at 5:50 PM and included the facility providing Residents #50 and #162 tablets programmed with the video relay interpreting service that were always accessible to the resident. Education was provided to the staff and residents on their use. The tablets were to be kept in the resident's rooms. - The second plan for immediacy was approved on 4/12/2025 at 11:14 PM, following determination staff and residents were unable to use the tablet for communication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- The facility provided in-service education to 89.5% of staff as of 4/16/2025 at 10:50 AM, with plans for ongoing education of staff not currently on the schedule, prior to the start of their next shift. - Multiple interdisciplinary staff were interviewed during onsite visits through 4/16/2025. All staff demonstrated knowledge of the education provided regarding the communication devices.

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	04/18/2025

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 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** 48052 48446 Based on observations, record review, and interviews during the recertification survey conducted 4/6/2025-4/18/2025, the facility did not ensure a safe, clean, comfortable, and homelike environment for four (4) of six (6) resident units (Units 3 North and South, Units 4 North and South, Units 6 North and South, and Unit 7) reviewed. Specifically, several residents' rooms and common living areas were unclean, had scraped or cracked walls, dirty soiled linens left on the floors, dirty tables and chairs, several pieces of paper trash collecting on resident floors, and there were unpleasant/offensive odors. Findings include: The facility policy Dignity and Respect, dated 8/2023 documented staff must ensure they provided residents with a safe, clean, and comfortable room and surroundings. Units 3 North and South The following observations were made on 4/6/2025: - at 9:30 AM, room [ROOM NUMBER] had a scraped wall behind the bed, the wall under the base board was crumbling, there was a hole cut out for an electric outlet with old phone wires hanging out. There were medicine cups, old bed frame wheels under the resident bed with dust and spider webs, and food crumbs and dust on the baseboards. - at 10:04 AM, there was a strong odor of urine in the back hallway near the exit and room [ROOM NUMBER], several chairs in the hallway, coffee stains on the floor, room [ROOM NUMBER]'s bathroom sink was unclean, a chair at the end of the hallway in front of room [ROOM NUMBER] had a brown substance on it, the television room's toilet had a dark brown substance in the bowl and smelled of urine. - at 10:07 AM, the dining area had several tables with dried coffee, and bits of dried cereal. - at 11:13 AM, a chair located in the hallway had a brown/yellow stain in the middle of the seat approximately 4 inches wide. - at 11:35 AM, room [ROOM NUMBER] had a wheelchair cushion with a brown stain, the nightstand was missing the top drawer, and there were brown splatters on the wall where the television was supposed to be. - at 1:54 PM, room [ROOM NUMBER] had a soiled brief containing feces on the floor of the bathroom. - at 2:08 PM, the alcove across from room [ROOM NUMBER] had a commode and a brief on the floor. The following additional observations were made: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- From 4/7/2025- 4/18/2025, the chair outside of room [ROOM NUMBER] was unclean with a dark brown substance. - on 4/07/2025 at 6:56 AM, there was a strong urine odor in the dining area and near the elevator entrance. - on 4/7/2025 at 10:31 AM, there was a commode in the alcove. Units 4 North and South The following observation were made on 4/6/2025: - at 10:54 AM, there was a red splatter on the wall outside the bathroom and a ceiling tile had a brown stain. - at 11:18 AM, room [ROOM NUMBER] had an orange sized hole in the wall under the light switch by the head of the bed, a black line mark from the door to the right of the head of the bed. - at 11:22 AM room [ROOM NUMBER] smelled of urine and, there a mat on the window side of bed with a large brown stain on it. - at 12:12 PM, room [ROOM NUMBER]D had bed linens lying the on floor. - at 12:41 PM, Resident #170 stated their room was always a mess and they did not like it. They stated housekeeping staff never wiped down the counters. The only thing that was done routinely was emptying the trash, but it was not done every day. They cleaned their own room and wiped down the counters. - at 2:39 PM, room [ROOM NUMBER] had a pillow with a brown/red stain on the pillowcase. - at 2:42 PM, room [ROOM NUMBER] had personal clothes in a yellow bag lying on the floor. - at 2:51 PM, room [ROOM NUMBER] had a purple substance spilled on the floor in front of the bedside stand, and the over bed table had dried purple liquid on the top and was sticky. The following observation were made on 4/7/2025: - at 6:25 AM, room [ROOM NUMBER] had food wrappers on the floor. The room was filled with food and bags. - at 6:34 AM, room [ROOM NUMBER] had gloves on the floor turned inside out. There was a strong smell of urine, no pillowcase on the pillow, crumbled up napkins and tissue on the floor surrounding the trash can, under the bed, and behind the nightstand. - at 8:02 AM, there was a pink/white stain along the floor outside the oxygen storage room, and a large black taped area on the floor between resident rooms. - at 8:31 AM, room [ROOM NUMBER] had dirty linen on the floor outside the bathroom. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- at 8:43 AM, room [ROOM NUMBER] had a strong smell of urine, and there were brown stained wet towels lying on the floor by the door. - at 9:06 PM, the 4A hall had a discolored brown washcloth in the middle of the hallway in front of nurse's station. During an observation on 4/08/2025 at 9:16 AM, room [ROOM NUMBER]'s soap dispenser was cracked on the wall, and there was no soap in the dispenser. Units 6 North and South The following observation were made on 4/6/2025: - at 9:56 AM, there were 3 large trash bags piled up outside of the sixth-floor conference room. - at 9:58 AM, there was a strong foul odor in the hallway outside of rooms 651-653. - at 10:20 AM, there was a bed frame in the hallway between rooms [ROOM NUMBERS] on the opposite side of the linen cart, making is difficult to pass in the hallways, and there was a two-seat couch next to the fire door on the same side of the linen cart. - at 12:19 PM, room [ROOM NUMBER] had a strong urine smell, and there was paper on the floor that was wet and yellow. - at 1:03 PM, room [ROOM NUMBER] had food and other debris on the floor, dirty personal dishes all over the room, soda can tabs scattered all over the room, the floor was sticky, there was half eaten and uneaten food, food stains on the sheets, and fast-food wrappers on the floor. During an observation on 4/8/2025 at 1:02 PM, there was a soiled, wet towel on the floor outside of room [ROOM NUMBER]. At 9:21 PM, the core area to the right of exit from the elevator smelled of urine. Unit 7: During an observation on 4/07/2025 at 6:12 AM, the counter in the 7th floor dining area was lined with approximately 7 dirty meal trays, some piled on top of each other. During an interview on 4/15/2025 at 11:51 AM, Licensed Practical Nurse #6 stated every unit staff person was responsible for emptying trash and putting a new trash can liner in, and dirty linen bags should be emptied when care was done for a resident. Splatters on walls should be initially cleaned by nursing staff and then housekeeping staff to sanitize the area after the initial clean. Environmental issues were supposed to be entered into the ringer system that went to maintenance to alert them of the issue that needed to be addressed. Dining room tables should be cleaned by nursing staff and housekeeping. They stated whoever found the mess, should be cleaning it up. The unit manager was also responsible to make rounds on the environment and address the issues. Soiled briefs should be placed in a clear trash bag and should not be on the floor in the hallway. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/15/2025 at 12:01 PM, Housekeeper #82 stated they were responsible for cleaning dining room tables before and after meals. They were also responsible for cleaning the floor and emptying out the garbage cans. During an interview on 4/15/2025 at 12:10 PM, Registered Nurse Unit Manager #9 stated all environmental issues should be entered as a work order for maintenance. Housekeeping staff were responsible to clean the core dining areas and dietary staff cleaned the kitchen areas. Those areas were also cleaned by the night shift housekeeping staff. They stated garbage cans should be emptied by housekeeping and a new liner placed in the can. Nursing staff were supposed to remove bags after care and put a new liner in the trash can. Floor mats were to be cleaned by nursing staff and housekeeping was responsible to sanitize them. Soiled briefs should be placed in a trash bag and not left on the floors in the hallways. During an interview on 4/15/2025 at 1:19 PM, the Director of Maintenance stated all staff were trained on how to enter work orders. If there were walls that needed patching, that would take longer because they had to sand and then paint. The certified nurse aides cleaned the wheelchairs during the night shift and the Director of Housekeeping rounded to ensure this was completed. During an interview on 4/15/2025 at 1:24 PM, the Interim Director of Housekeeping stated the wheelchairs were cleaned between nursing and housekeeping and there was a schedule for cleaning them. Housekeeping was responsible to pick up soiled linen from the utility rooms. The housekeepers were also required to clean the dining area and kitchenettes. Nursing staff were responsible to clean soiled floor mats and let housekeeping know if they needed to be sanitized. Both nursing and housekeeping staff were responsible for emptying trash cans and replacing the bag. 10 NYCRR 415.29(j)(1)

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	04/18/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48052 48895 Based on observations, interviews, and record review during the recertification survey conducted [DATE]-[DATE], the facility did not ensure a resident's right to be free from misappropriation of property/funds for two (2) of two (2) residents (Residents #50 and #102) reviewed. Specifically, Activity Aide #5 had possession of Resident #50's money; and Resident #102 had multiple bags of deposit cans redeemable for cash removed from their room and did not receive the deposit money. Findings include: The ,d+[DATE] facility Staff Member Handbook documented the expectation was all staff members would conduct themselves in a professional manner that would contribute to the provision of the highest quality of care for the residents and the safety and security of residents. Just cause for discipline, up to and including termination would include but not be limited to: accepting gratuities (except for in kind gifts of a minimal value, e.g., baked goods) from residents, family members, supplies, or vendors. 1) Resident #50 had diagnoses including deafness, and non-speaking. The [DATE] Minimum Data Set assessment documented the resident was cognitively intact and independent with activities of daily living. The Comprehensive Care Plan revised [DATE] documented the resident was a potential victim of abuse due to their inability to communicate their needs effectively. Interventions included offering diversional activities, snacks, and toileting; redirect resident away from persons of concern; and encourage resident to spend leisure time in supervised areas. During an interview on [DATE] at 11:07 AM, Ombudsman #101 stated the Administrator, Assistant Administrator, and the Director of Nursing were made aware on [DATE] at approximately 12:00 PM, at their weekly meeting, that Activity Aide #5 had approximately $400.00 of Resident #50's money. The Administrator stated they would start an investigation. Ombudsman #101 stated they were not provided any information or updates regarding the situation with Resident #50's money. During an interview on [DATE] at 2:20 PM, Resident #50 communicated via in-person certified American Sign Language Interpreter #53 that Activity Aide #5 wanted to be the resident's friend and to learn American Sign Language from them. Activity Aide #5 asked the resident to do things like putting together a puzzle or play a board game, and the resident trusted them. Resident #50 stated they gave Activity Aide #5 $400.00 to hold on to for them sometime in ,d+[DATE]. When Resident #50 asked for the money back Activity Aide #5 stated they only had $300.00 remaining. They were waiting to hear back from Activity Aide #5 and had not seen them in a long time. Activity Aide #5 told the resident they were struggling to provide care for a family member and was not working as much. Resident #50 stated that they were not aware the facility could hold money for them in an account. They felt embarrassed, they became visibly upset about the financial situation and not understanding how the process worked. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The [DATE] file from the Administrator titles Misappropriation of Resident Property Investigation, documented Activity Aide #5 clearly had the resident's consent, given the money was given over time. There was no evidence of taking anything without consent. There was no misplacement. The resident gave them the money and did not misplace or take any funds. The aide promptly returned the balance when asked to do so. There was no evidence they used the funds for personal use. In summary, the action was a bad judgement call, Activity Aide #5 was educated upon hire regarding our gifts and gratuities policy. However, this was not a gift, the money was not for their use. They returned the balance of funds with some receipts for food items requested by the resident. The following documents were included in the file: - on [DATE], a high priority electronic communication from Deaf Services Manager #18 (from local advocacy agency for the Deaf) to Social Worker #121 documented Resident #50 was visited and reported giving $400. 00 to the activity director because they brought the resident coffee and was nice to them. The resident had an additional $200.00 that was returned to their account. They requested the concern be investigated. If the aide still had the resident's $400.00, the resident would like to deposit it back into their bank account. - on [DATE] Activity Aide #5 was placed on administrative leave. - A balance of $819.00 was returned to the facility on [DATE], along with 2 shopping lists and 2 receipts. The receipts totaled $11.45. - The [DATE] Activity Aide #5's statement documented Resident #50 asked them to hold $1,000.00 for them and if they died , they wanted them to keep it safe. The resident asked them to go shopping, and they would use the money from the resident. They helped the resident because the resident felt they could not communicate with the staff for their needs. - The [DATE] statement by the Director of Social Work and Social Worker #37 documented they interviewed Resident #50 on [DATE]. The resident stated there were 3 people holding money for them and Activity Aide #5 was one. Resident showed social work the types of items received from the store. The Director of Social Work asked the amount of money given and the resident showed $300.00 to Recreation Therapist #5. The statement was signed [DATE] at 6:37 AM. - Photos of the white board communication included the 3 names and included Activity Aide #5 and My friend [Activity Aide #5] hold my money $300 now. - The [DATE] Social Worker #121's statement documented on [DATE] they were made aware by nursing staff that Resident #50 may have exchanged $400.00 with an activities staff member. They attempted to engage the resident with the white erase board, Resident #50 got angry, and the Social Worker left the room. They attempted to contact the resident's Case Manager (from local advocacy agency for the Deaf) and left a message for American Sign Language Interpreter #53, the phone message was not returned. - The [DATE] Licensed Practical Nurse Assistant Unit Manager #122's statement documented on [DATE] staff reported that Resident #50's case workers reported the resident gave $400.00 to someone to help them sign and had an additional $200.00 waiting for them. They reported the incident to Social Worker #121. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	- The [DATE] Certified Nurse Aide #123 statement documented Resident #50's visitors stated the resident gave someone $400.00 for helping them and was going to give that person another $200.00 that day. Activity Aide #5's timecard documented they worked and continued to have access to all residents on [DATE], [DATE], and [DATE]. They were scheduled to work [DATE], [DATE], [DATE], [DATE], and [DATE], but were out of work due to illness. During an interview [DATE] at 4:28 PM, the Administrator stated they had an ongoing investigation for Resident #50. The Ombudsman told them on [DATE] or [DATE] that Resident #50 had an employee handling money for them, and they did not know who the employee was. They just found out on Monday [DATE] who the employee was based on the name, and they were interviewed on [DATE]. The staff had returned $819.00 and had some receipts to the resident. Activity Aide #5 told them they received $1,000. They took the money to hold it so the resident could keep it safe, and they felt like the resident could not communicate their needs. They stated they did not have all the receipts, and the receipts they do have did not add up to the difference. There were 2 receipts for [a local grocery store] for 4 donuts and one receipt for a banana and donuts. The resident opened a bank account at a local credit union. The resident was cognitively intact and trusting. They had a policy on accepting gifts and money including staff members were prohibited from accepting gifts or gratuities and may end up terminated. During the investigation they had to rule out misappropriation. Misappropriation was deliberate exploitation or wrongful temporary or permanent use of belongings without the resident consent. The resident had two lists of requested items. Resident stated they gave the staff $300.00. During an interview on [DATE] at 9:15 AM, Activity Aide #5 stated they did not work with Resident #50 regularly, as they were not assigned to that unit. They communicated with the resident in Sign Language, they were in school for American Sign Language. Resident #50 gave them $1,000.00 in cash in mid-[DATE] and the resident wanted them to have it if they died . They were afraid they were dying because of the severe stomach pain they were having, and afraid the nurses were going to take the money. The resident asked them to go shopping for them because there was not enough food in the facility. During a follow-up interview on [DATE] at 2:30 PM, the Administrator stated the whiteboard was used to interview Resident #50 and they were not sure if they got a detailed view of the situation from the resident using the whiteboard. They did not clarify what the resident meant by their My friend [Activity Aide #5] hold my money $300 now statement. They were not sure how the facility ensured the resident understanding, and did not provide the resident an interpreter. During an interview on [DATE] at 10:37 AM, Certified Nurse Aide #123 stated the 2 people from the Deaf Advocacy Program that visited Resident #50 told them about a month ago the resident had given someone money. They reported it to Licensed Practical Nurse Assistant Unit Manager #122. They stated they should not take gifts or money from residents because it was not allowed and against the policy. During an interview on [DATE] at 10:49 AM, Licensed Practical Nurse Assistant Unit Manager #122 stated it was reported to them that a [staff member] was given money from Resident #50, at the end of February or early March. They reported it to Social Worker #121. The stated staff should not take money or gifts from residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on [DATE] at 11:55 AM, Social Worker #121 stated they met with Resident #50 about the money situation and the resident did not want to talk about it. They were made aware of the staff member that took the money; they did not know how they knew; they just did. The staff member was learning Sign Language from Resident #50. They attempted to reach out to American Sign Language Interpreter #53 on [DATE] and left a message. They did not start an accident or incident report, and they did not recall going to Administration about the situation. It was not appropriate for staff to take money from a resident. During a follow-up interview on [DATE] at 12:40 PM, the Administrator stated Activity Aide #5 returned $819. 00 of Resident #50's money they were holding. They did not report the financial situation to any agency outside the facility. They did not consider the holding of the resident money financial abuse, just poor judgement. Activity Aide #5 was not able to produce receipts for the $181.00 difference. The Administrator stated they did not necessarily consider the inability to account for the complete $181.00 as misplaced funds. They did not expect Social Worker #121 to report the financial abuse or misappropriation of funds to the Administrator, they should start the investigation first, which was what they did. 2) Resident #102 had diagnoses including depression and post-traumatic stress disorder. The [DATE] annual Minimum Data Set documented the resident had intact cognition and it was very important to the resident to take care of their personal belongings. The [DATE] Comprehensive Care Plan documented the resident was a trauma survivor. Approaches included staff were to be consistent, positive and honest as well as non-judgmental and be respectful of the resident's personal space and reassure resident of their safety and security. The [DATE] Director of Social Work progress note documented a deep room clean was completed, and cans were removed. The resident was encouraged to keep their room clean to avoid future issues and the resident was agreeable. During an interview and observation on [DATE] at 2:45 PM, Resident #102 stated they were holding cans in their room to turn them in for the deposit so they could buy things for themself. They had bags of cans at one point, but the facility made them get rid of them. The cans were given to a staff member to cash in for them, but they never received the money. They stated they needed money to get a copy of their birth certificate so they could obtain housing and leave the facility. During a follow up interview on [DATE] at 11:41 AM, the resident stated they had made it clear to the facility they wanted the cans to be cashed in and the money was to be given back to them. They were told it was not the facility's problem they wanted to cash in the cans and the Administrator wanted the cans thrown out. The resident stated Housekeeper #112 wanted the cans for themself, and the Director of Social Work told them they did not care what happened to the cans if they were out of the building. During an interview on [DATE] at 9:09 AM, [NAME] Clerk #111 stated the resident had a lot of cans in their room at one point. The shower in the resident's room was filled with bags of cans and empty bottles. They stated the resident gave the bags to someone in housekeeping to return for money on their behalf, but the housekeeper never returned the money to the resident. They were not sure if the resident filed a grievance about this. They did not report the situation to any supervisors as the resident had told them they had already talked to the Nursing Supervisor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on [DATE] at 10:03 AM, the Director of Social Work stated they assisted the resident with getting rid of the bags of cans in their room as they were not redeemable and did not have a value due to most of them being small, off-brand cans. To their knowledge, the cans were taken down to the loading dock to be recycled and disposed of. During a follow up interview on [DATE] at 10:12 AM, the Director of Social Work stated they were previously mistaken, and the cans did have a refundable value. They brought the issue to Administration once they found out the cans had value. They did not know what happened with the money from the redeemed cans. They were unsure since the cans did have value and were removed by staff without the resident's permission if it would be considered misappropriation of a resident's property. During a telephone interview on [DATE] at 9:30 AM, Housekeeper #112 stated Administration had removed the bags of cans from the resident's room and instructed them to throw out the cans. Housekeeper #112 stated they were not going to throw them out, so they took them. They stated they picked up cans every day on the job. They stated they confirmed with the resident they cashed in the cans. If the resident wanted to cash in the cans or the facility was letting the resident save the cans so they could cash them in, they should not have had staff get rid of them. During an interview on [DATE] at 12:40 PM, the Administrator stated they were not aware of recycled cans being taken from Resident #102 and cashed in. They were only looking at the situation from an infection control and pest control standpoint. The resident collected the cans from the dining room tables after meals, and from other residents who donated the cans to them. The facility did not have a means for residents to cash in recyclable cans collected to redeem cash. 10 NYCRR 415.4(b)

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	04/18/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 48052 48895 Based on observations, record review, and interviews during the recertification survey conducted 4/6/2025-4/18/2025, the facility did not ensure all alleged violations were thoroughly investigated and a plan was implemented to prevent further potential abuse for one (1) of three (3) residents (Resident #419) reviewed. Specifically, Resident #419 sustained a burn from a hot liquid that was not reported to the New York State Department of Health as required. Findings include: The facility policy Reporting and Monitoring Accidents and Incidents, revised 1/2024, documented the facility would report and investigate any accident/incident involving a resident of the facility. The New York State Department of Health Nursing Home Incident Reporting Manual dated 8/2016 documented an accident resulting in a burn to the body surface was reportable to the New York State Department of Health. Resident #419 had diagnoses including paralysis of the left side following a stroke and. The 2/6/2025 Minimum Data Set documented the resident was cognitively intact and required supervision or was independent with most activities of daily living. The untimed 3/15/2025 Licensed Practical Nurse Assistant Unit Manager #7 progress note documented they were called to the unit due to Resident #419 stating they had burned themself accidentally. They interviewed the resident who stated they were pouring hot water out in their bathroom sink when it slipped out of their hands and splashed on them. The resident had small superficial burns that blistered on their lower abdomen as well as the upper inner thigh. The resident stated that it was an accident, and they denied pain. They notified the on-call providers and were awaiting a return call. The untimed 3/17/2025 Registered Nurse Unit Manager #9 progress note documented they assessed the resident, and the resident had a pink area noted to the left upper thigh where the resident stated they had burned themself on 3/15/2025. The resident denied pain or discomfort. They were seen by the nurse practitioner and there were no new orders at that time. The 3/17/2025 Nurse Practitioner #48 progress note documented the resident had a small burn to their thigh that occurred when they were taking something out of the microwave and it spilled on them which caused the burn. The resident had told staff they were pouring hot water in their sink, and it splashed on them. The resident denied pain and there were no signs on infection. The plan was to continue to monitor the superficial burn to the left thigh. The facility 3/15/2025 Incident/Accident report documented: - the supervisor was called to the floor related to the resident stating they had burned themself with hot water at 5:45 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	- the resident had small superficial burns to their lower left abdomen and their left inner upper thigh. The burns appeared to be blistered. The resident was lying in bed during the observation and had no complaints of pain. - Resident #419's verbal statement transcribed by Licensed Practical Nurse Assistant Unit Manager #7 documented they were pouring hot water out in the bathroom sink when it slipped out of their hands and spilled on them. - the on-call provider and Nurse Practitioner #48 were notified on 3/15/2025 at 6:00 PM. No orders were given. - Certified Nurse Aide #161's statement documented at 5:35 PM, they were sitting at the nurses' station when the resident was in the staff breakroom behind the nurses' stations heating up their food in the microwave. They overheard the resident laugh about burning themself. - Licensed Practical Nurse #6's statement documented they were asked by the resident to heat up their food. They put the resident's food in the microwave in the breakroom. They walked away and when they made it back by the nurses' station, the resident was wheeling out of the breakroom with their food and stated they burned themself. - Certified Nurse Aide #162's statement document they walked into the breakroom as the resident was rolling out in their wheelchair laughing about how they had burned themself getting their food out of the microwave. - The resident was assessed by Registered Nurse Unit Manager #9 and Nurse Practitioner #48 on 3/17/2025. The resident's small blisters to their left lower abdomen had resolved and they had a small pink area to their thigh. - The summary of the incident documented the incident was determined to be self-inflicted while removing their food from the microwave without staff assistance. The facility determined the incident was not reportable to the New York State Department of Health. During an observation and interview on 4/8/2025 at 2:07 PM Resident #419 stated the burns occurred when they were cooking their food in the microwave and poured out the hot water in their room sink. They stated they wanted ground turkey which they preferred to be cooked in the microwave in hot water. Licensed Practical Nurse #6 informed them they were not allowed to use the microwave behind the nurses' station anymore and heated up the meat for them. The resident stated they were straining the water out in their bathroom when the bowl slipped and splashed hot water on them. During an interview on 4/10/2025 at 9:22 AM, Licensed Practical Nurse Assistant Unit Manager #7 stated they were one of the supervisors on duty when Resident #419 was burned. They went to the unit and observed the resident had bubble blisters on the left thigh and left side of their abdomen. They informed the Registered Nurse Supervisor, the Director of Nursing, and the on-call medical providers. They obtained statements of the incident and were directed by the Director of Nursing to fill out the Accident and Incident form. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 4/10/2025 at 2:14 PM, the Director of Nursing stated they were made aware of Resident #419's burn by Licensed Practical Nurse Assistant Unit Manager #7. The incident was not reported to the New York State Department of Health as they were unaware surface burns had to be reported. 10 NYCRR 415.4 49448

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	04/18/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48895 49448 Based on observations, record review, and interviews during the recertification survey conducted 4/6/2025-4/18/2025, the facility did not ensure allegations of abuse, neglect, or mistreatment were thoroughly investigated for one (1) of nine (9) residents (Resident #50) reviewed. Specifically, the facility did not complete a timely investigation when they were notified a facility staff member was in possession of Resident #50's money (see F 602) and did not report the incident to the New York State Department of Health as required. Findings include: The facility policy Reporting and Monitoring Accidents and Incidents, revised 9/2024 documented all incidents were reviewed for alleged abuse, mistreatment, neglect, injury of unknown origin, misappropriation of resident property, or resident elopement and must be reported to Administration immediately. The incident report system was used to document, assess, investigate and develop interventions for any accident/ incident that involved a resident. A description of the incident was provided on the incident report, and based on observations, interviews, and record review, if causative factors were identified, resident specific interventions were developed. Resident #50 had diagnoses including diabetes, deafness, and non-speaking. The Minimum Data Set assessment dated [DATE] documented the resident was cognitively intact, and independent with activities of daily living. During a telephone interview on 4/7/2025 at 10:11 AM, Ombudsman #101 stated they met with the Administrator, Assistant Administrator, and the Director of Nursing weekly. Resident #50 gave $400 to a staff member and Administration was going to look into it, they started an investigation without an interpreter. They asked the resident questions on a white board, but they used to have a tablet for interpretation that had not been seen in a long time and was locked up at night. The facility grievance log reviewed from 10/8/2024-4/3/2025 did not include any grievances for Resident #50. The 3/2025 and 4/2025 facility Accident and Incident Reports did not include accidents or incidents for Resident #50. During a follow up interview on 4/9/2025 at 11:07 AM, Ombudsman #101 stated the Administrator, Assistant Administrator, and Director of Nursing were made aware on 3/28/2025 at approximately 12:00 PM that Activity Aide #5 had approximately $400 dollars of Resident #50's money. The Administrator stated they would start an investigation. The Ombudsman stated they were not provided with updates regarding the resident's money. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	As of 4/9/2025 at 11:31 AM, Resident #50 was not included in the provided accident and incident reports. At 11:33 AM, Administrative Assistant #159 stated all opened/active investigations and completed investigations were already provided to the survey team. There was no documented evidence of an investigation, accident/incident report, or active grievance investigation for Resident #50. During an interview on 4/9/2025 at 2:20 PM, Resident #50 communicated via in-person certified American Sign Language Interpreter #53 and stated Activity Aide #5 wanted to be their friend and wanted to learn sign language. Activity Aide #5 asked the resident to do things like putting together a puzzle or play a board game, and the resident trusted them. Resident #50 stated they gave Activity Aide #5 $400 to hold on to for them. When Resident #50 asked for the money back Activity Aide #5 stated they only had $300 remaining. They were still waiting to hear back from Activity Aide #5, and they had not seen them in a long time. Activity Aide #5 said they were struggling to provide care for a family member and was not working as much. Resident #50 stated that they were not aware the facility could hold money for them, or they could have a separate account. During an interview 4/9/2025 at 4:28 PM, the Administrator stated they had an ongoing investigation for Resident #50 they had forgotten to provide the survey team. The Ombudsman told them on 3/28/25 or 3/29/25 Resident #50 had an employee handling money for them. The did not know who the employee was. They just found out on Monday 4/7/2025 who it was based on the name and originally thought it was a nursing staff. When they finally realized who it was, Activity Aide #5 was interviewed on 4/8/2025. Activity Aide #5 returned $819 and had some receipts and had received $1,000. Activity Aide #5 took the money to hold it so the resident could keep it safe, as they felt like the resident could not communicate their needs. The facility had a policy on accepting gifts and money which documented staff members were prohibited from accepting gifts or gratuities and could be terminated. The Administrator stated they had to rule out misappropriation. Misappropriation was deliberate exploitation or wrongful temporary or permanent use of belongings without the resident's consent. During an interview on 4/10/2025 at 10:29 AM, Social Worker #37 stated Resident #50's primary language was American Sign Language. They interviewed Resident #50 regarding who was handling their money. They conducted the interview with the resident via whiteboard. The resident was taken advantage of financially in the community and then with this situation in the facility. They felt they were able to get details from the resident's perspective as they were just looking for basic information. The resident was able to write the names of the people and the amounts of money they gave to them. During a follow-up interview on 4/10/2025 at 2:30 PM, the Administrator stated Resident #50's primary language was American Sign Language and the interview for the financial situation was conducted via whiteboard. They were not sure if they got a detailed view of the situation from the resident's perspective with the use of the whiteboard. They were not sure how the facility ensured informed consent for Resident #50. They did not provide Resident #50 an interpreter to better understand the situation. During an interview on 4/17/2025 at 10:37 AM, Certified Nurse Aide #123 stated they were made aware by the two people from the Deaf advocacy program who visited Resident #50, that the resident gave money to someone, and they reported it to Licensed Practical Nurse Assistant Unit Manager #122 about a month ago. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 4/17/2025 at 10:49 AM, Licensed Practical Nurse Assistant Unit Manager #122 stated staff made them aware of Resident #50 giving money to someone about 6 weeks ago. They reported it to Social Worker #121. During an interview on 4/17/2025 at 10:56 AM, Licensed Practical Nurse Unit Manager #22 stated they were unaware of Activity Aide #5 was holding Resident #50's money until after the State came to the facility. The Administrator brought it up, but Social Worker #121 and the Director of Social Work were handling it. During an interview on 4/17/2025 at 11:55 AM, Social Worker #121 stated they met with Resident #50 about the money situation and the resident did not want to talk about it. They were made aware of the staff member that took the money; they did not know how they knew they just did. They did not start an accident or incident report, and they did not recall going to administration about the situation. On 4/15/2025, all parts of investigation/ incident reports were requested from the facility. The 4/16/2025 at 2:43 PM electronic communications by the Administer documented that Resident #50 did not have any grievances or incident reports. During an interview on 4/17/2025 at 4:15 PM, the surveyor reviewed the electronic communication with the Administrator that documented there were no grievances or incident reports for Resident #50. The Administrator stated that was correct. They were reminded of the investigation reviewed together the previous week. They stated, Oh, that one, it's not completed. When asked if the investigation had been open for more than 5 days, given the reported date was 3/28/2025, the Administrator stated the investigation was not started on 3/28/2025, but they would provide what they had. The 4/17/2025 facility document file from the Administrator titled Misappropriation of Resident Property Investigation, documented Activity Aide #5 clearly had the resident's consent, given the money was given over time. There was no evidence of taking anything without consent. There was no misplacement. They gave them the money and they did not misplace or take any funds. They promptly returned the balance when asked to do so. There was no evidence they used the funds for personal use. In summary, the action was a bad judgement call, they were educated upon hire regarding the gifts and gratuities policy. However, this was not a gift, the money was not for their use. They returned the balance of funds with some receipts for food items requested by the resident. The 4/8/2025 statement by the Director of Social Work and Social Worker #37 documented they interviewed Resident #50 on 4/8/2025 and wrote the following statement. On this date at approximately 5:30 PM, resident said there were 3 people holding money for them, Recreation Therapist #5 was one. Resident showed social work the types of items received from the store. Director of Social Work asked the amount of money given and the resident showed $300 to Activity Aide #5. The statement was signed 4/8/2025 at 6:37 AM. The 4/10/2025 Social Worker #121's statement documented on 3/13/2025 they were made aware by nursing staff that Resident #50 may have exchanged $400 with an activities staff member. They attempted to engage the resident with the white erase board, Resident #50 got angry, and the Social Worker left the room. They attempted to contact the resident's case manager and left a message for American Sign Language Interpreter #53; the phone message was not returned. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a follow up interview on 4/18/2025 at 11:37 AM, Social Worker #121 stated with the information they received on 3/13/2025, they considered the situation to be abuse. They reported it to their supervisor, the Director of Social Work. During an interview on 4/18/2025 at 11:43, the Director of Social Work stated they were not made aware of the situation on 3/13/2025, and they only started their own investigation into new items in the resident room on 4/10/2025. During an interview on 4/18/2025 at 12:40 PM, the Administrator stated they were made aware of the financial situation by the Ombudsman at the end of March but could not recall the exact date. The resident was interview on 4/8/2025 and they confirmed the staff member's name. They did not interview any one on the unit before 4/8/2025, because there was not a lot of information to go off. They did not report the financial situation to any agency outside the facility. They did not consider the holding of the resident money financial abuse, just poor judgement. Activity Aide #5 was not able to produce receipts for the $181 difference. The Administrator stated they did not necessarily consider the inability to account for the complete $181 as misplaced funds. They did not expect Social Worker #121 to report the financial abuse or misappropriation of funds to the Administrator. They expected them to start the investigation first, which was what was they did. If the situation was communicated to them with the staff member's name, they would have started the investigation right away. 10NYCRR 415.4(b)(3) 50561

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	04/18/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 51469 Based on observations, record review, and interviews during the recertification survey conducted 4/6/2025 - 4/18/2025, the facility did not ensure the accuracy of resident assessments reflective of the resident's status during the observation period of the Minimum Data Det assessment for one (1) of three (3) residents (Resident #200) reviewed. Specifically, the most recent Minimum Data Set Resident Assessment inaccurately documented the resident as nonverbal and severely cognitively impaired. Findings include: The facility policy Accuracy of the Resident Assessment, revised 6/24/2016, documented all personnel who complete any portion of the Minimum Data Set Assessment, tracking form, or correction request form must sign assessment certifying the accuracy of that portion of the assessment. Resident #200 had diagnoses cancer of the mouth and throat with absence of larynx (voice box) and had a tracheostomy (a hole created in the neck into the windpipe). The 2/18/2025 Minimum Data Set Assessment documented the resident had absence of spoken word, was sometimes able to express ideas and wants, and was sometimes understood. The Brief Interview for Mental Status (a tool used to evaluate cognition) was unable to be completed as the resident was rarely/never understood. The staff assessment for mental status documented the resident's cognitive skills for daily decision making were severely impaired. The 9/4/2024 resident care instructions documented for communication explain and speak clearly, face the resident with speech; allow time for the resident to gesture for communication; point to items while discussing them; ask resident yes or no questions; and the resident would shake their head yes or no and use hand gestures for communication. The 1/27/2025 Registered Nurse #174 Nursing Readmission Assessment (readmitted from the hospital) documented the resident could usually make themself understood, did not speak, and was able to understand others. The 1/29/2025 Medical Director/Physician #3 Initial History and Physical documented review of systems was limited by dementia; the resident had no complaints. The 2/18/2025 Minimum Data Set assessment documented Registered Nurse Minimum Data Set Coordinator #120 signed as completing Section C-Cognitive Patterns. The completion of section B- Hearing, Speech, and vision was cut off and unable to be determined who completed the section. During an observation on 4/8/25 at 8:53 AM Licensed Practical Nurse #7 provided Resident #200's tracheostomy care. The resident indicated via a whiteboard they chose to remove the speaking valve (a one-way valve that helps the resident to speak) for the tracheostomy when they slept and, in the morning, following tracheostomy care they put the speaking valve in place for the day. The resident then used the speaking valve for the remainder of the interaction with Licensed Practical Nurse #7. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan initiated 1/11/2025 revised 4/8/2025 documented the resident had a problem with communication; had no speech; shook their head yes or no and used hand gestures for communication; explain and speak to resident clearly; face resident, speak slowly and enunciate distinctly; encourage the use of communication board; time should be allowed for resident to gesture for communication; monitor for changes; ask yes or no questions; resident would shake head and gesture for communication. There was no documented evidence of the resident's use of a speaking valve. During an observation on 4/15/2025 at 10:18 AM Licensed Practical Nurse #6 entered the resident's room, the resident verbally indicated they needed to be suctioned, and the Licensed Practical Nurse confirmed the request and completed the task. The resident replaced the speaking valve, and the Licensed Practical Nurse asked if there was anything else they needed before they left the room, the resident stated, no thank you and stated the name of Licensed Practical Nurse # 6. During an interview on 4/8/2025 at 8:53 AM Resident #200 stated they preferred to talk with their speaking valve. The resident placed the speaking valve and stated they were diagnosed with tonsil cancer five years ago which resulted in a tracheostomy in 7/2024. Until a speaking valve device was available, they communicated with a white board but since acquiring the speaking valve device they only used the white board when the speaking valve device was cleaned. During an interview on 4/15/2025 at 9:16 AM Licensed Practical Nurse #6 stated the resident had no problem communicating their needs. The resident removed the speaking valve at times but was always able to access it. During an interview on 4/15/2025 at 10:18 AM Certified Nurse Aide #115 stated the resident could always verbalize exactly what they needed, and the resident was cognitively intact. During an interview with resident's significant other on 4/15/2025 at 1:30 PM they stated they had a difficulty when they attempted to obtain notary service from the business office. They stated the facility notary denied the service, citing the residents cognitive score of zero (0). They stated the resident was never diagnosed with dementia and they were unaware of the origin of the diagnosis. The resident joked and stated the correct name of the President of the United States, the season, month, date, day and year. They further added, What else do you need to know? During an interview on 4/16/2025 at 11:01 AM Business Office Notary #116 stated their responsibility as a notary was to determine if the resident had the cognitive capacity, specifically the resident required a score of nine (9) or above for the Brief Interview for Mental Status as indicated in Section C of the most recent Minimum Data Set assessment. They reviewed Section C of Resident #200's assessment and stated the resident had no score and that indicated Resident #200 was significantly cognitively compromised. They stated If the score was not correct that could impact the outcome for the resident's needs. During an interview on 4/17/2025 at 10:12 AM Social Worker #117 stated there were no guidelines for updating the Minimum Data Set quarterly for cognitive assessments. They commonly used the assessment from the initial Minimum Data Set and carried it over to the next. They stated they were not given instruction to redo it every quarter. They had never done a Brief Interview for Mental Status for the resident. They stated an inaccurate assessment of a resident's cognitive ability would not give the complete picture for the resident's capabilities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/2025 at 10:34 AM Registered Nurse Minimum Data Set Coordinator #120 stated the cognitive assessment should be completed quarterly. If a resident had impaired communication, they interviewed the resident to confirm the cognitive status was accurate. The Minimum Data Set information comes from specific departments assigned to their own section. Social work did the cognitive assessment which was either the staff assessment or Brief Interview for Mental Status and nursing was responsible for the communication section. They expected the social worker to accurately assess the resident every quarter. They were not aware the resident's cognition was not reassessed since admission. It was important to have an accurate assessment of the resident because the assessment drove care and could affect the quality of care. During an interview on 4/17/2025 at 1:30 PM Speech Language Pathologist #34 stated they worked with the resident when they first received their speaking valve. They stated the resident did great with it and learned quickly. There was no indication the resident's cognition was impaired, and the resident was quite sharp since their admission. During a telephone interview on 4/18/2025 at 12:40 PM Registered Nurse #118 stated the Minimum Data Set indicated the resident had no speech. This was their status since their admission. If there was not a significant change, they would look at the previous Minimum Data Set but, in this case, they stated they most likely looked at the care plan and if the care plan was inaccurate the Minimum Data Set information would be entered inaccurately as well. They explained they work remotely therefore relied on correct documentation to complete the care plans. They stated a Minimum Data Set assessments should reflect the resident within the time frame on the tool itself and this was a problem that cascaded from prior inaccurate assessments. 10NYCRR415.11(B)

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	04/18/2025

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 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. 50561 Based on observations, record review, and interviews during the recertification survey conducted 4/6/2025-4/18/2025, the facility did not develop and implement a comprehensive person-centered care plan for each resident to include services provided to maintain the resident's highest practicable physical well-being for one (1) of two (2) residents (Resident #372) reviewed. Specifically, Resident #372 did not have their wheelchair leg rests applied or included in their care plan as recommended by physical therapy. The facility policy Care Planning/Care Conference, issued 8/7/2024 documented the Comprehensive Care Plan should describe the resident's medical, nursing, physical needs and preferences and how the facility would assist in meeting those needs and preferences. The facility policy Wheelchair Transporting (Leg Rest), 2/2017 documented wheelchair leg rests must be used for all residents at all times unless otherwise care planned. Resident #372 had diagnoses including edema (swelling caused by fluid), gout (a type of arthritis), and rheumatoid arthritis (a chronic inflammatory disease affecting the joints). The 2/18/2025 Minimum Data Set assessment documented the resident utilized a wheelchair; required supervision to wheel self at least 150 feet in corridor; and required moderate assistance for transfers. The 1/29/2025 Minimum Data Set documented the resident had severely impaired cognition. The 2/28/2025 Nurse Practitioner #32 progress note documented the resident had lower extremity edema and the resident spent most of their time with their legs in a dependent position (legs dangle or hang down while sitting). The 3/11/2025 Physical Therapy Assistant #31's progress note documented a recommendation for a standard wheelchair with bilateral leg rests. The 3/11/2025 comprehensive care plan documented an activities of daily living performance/physical mobility impairment. Interventions included wheelchair when out of bed and handheld assistance to ambulate 50 feet. The Care Plan did include the recommendation by therapy for the use of bilateral leg rests. Resident #372 was observed sitting in their wheelchair without wheelchair leg rests and their feet dangling and not touching the floor on 4/7/2025 at 10:13 AM, 4/8/2025 at 9:03 AM, and 4/16/2025 at 9:56 AM. During an interview on 4/15/2025 at 10:10 AM, Certified Nurse Aide #27 stated if a resident's feet did not touch the ground, they should have leg rests because it provided support and helped with positioning. Slouching, improper positioning, and pain could occur if they were not provided. Resident #372 was in a wheelchair most of the time and their feet did not touch the floor when sitting in the wheelchair. They thought the resident had leg rests and was unsure why they did not have them on. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/15/2025 at 12:15 PM, Licensed Practical Nurse #26 stated therapy determined which residents should have leg rests. Residents who could not self-propel should have leg rests as it could cause edema and discomfort if they did not. Resident #372 used their arms to self-propel in the chair; received ace wraps to their legs; sometimes complained of knee pain; was in the wheelchair most of the day; and if therapy recommended the leg rests, they should have had them. During an interview on 4/15/2025 at 12:57 PM, Registered Nurse Unit Manager #29 stated all residents had wheelchair leg rests unless therapy recommended otherwise. If a resident's feet did not touch the floor while sitting in their wheelchair, they should have leg rests. If they did not have leg rests, it could cause dependent edema and exacerbate pain if the resident had arthritis. Resident #372 self-propelled in their wheelchair using their arms. Their feet did not touch the ground when sitting in the wheelchair. If therapy recommended leg rests, then the resident should have them. The resident had a diagnosis of edema and gout which made it even more important for the leg rests to be used. During an interview on 4/17/2025 at 10:11 AM, the Director of Rehabilitation Services stated all residents should have leg rests unless care planned not to. If a resident's feet did not touch the floor while sitting in their wheelchair, they should have leg rests as it could cause leg edema and discomfort. If therapy recommended leg rests, then they should be used. Resident #372 should have bilateral leg rests per the 3/11/2025 Physical Therapy Assistant #31's progress note and if the resident had edema, required leg wraps, and had chronic leg pain they should have leg rests. 10NYCRR 415.11(c)(1)

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	04/18/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48895 Based on observation, interview, and record review during the recertification survey conducted 4/6/2025-4/18/2025, the facility did not ensure that services were provided to meet professional standards of quality for five (5) of five (5) resident units (Units 3, 4, 5, 6, and 7) reviewed. Specifically, direct care staff wore electronic earbuds; were scrolling or talking on their personal phones in resident care areas; and were observed in the breakroom for extended periods longer than documented break/mealtimes or at the end of their shifts. Additionally, 12 of 12 residents present at the Resident Council Meeting complained staff did not answer their call bells timely, were rude, and made them feel disrespected. Findings include: The facility Staff Member Handbook, revised 10/2018, documented staff were permitted one 15-minute break for each 7.5 hours of work per day and a half hour meal period during a shift that lasted more than six hours. Cell phones were not to be used during working hours and may only be used in the staff break room or outside the facility before or after their scheduled shifts and during their scheduled break and meal periods only, except in cases of emergency. The facility policy Call Bells, effective 8/2/2022, documented call bells would be addressed as timely as possible with a goal of under 5 minutes. Resident interviews: During an interview on 4/6/2025 at 10:09 AM, Resident #355 stated staff were rude especially during nights and weekends. When staff arrived in the morning, they often did not know who their aide was until 9:30 or 10:00 AM. Most of the staff did not introduce themselves when they provided care. They stated administrative staff never came around and introduced themselves. Most days staff told them they were out of coffee, but they just did not make it. During an interview on 4/6/2025 at 10:20 AM Resident #212 stated staff were not trained properly, did not want to do their job, were rude, had attitudes, hid their badges and would not tell residents their names when asked. When they asked staff for help, staff told them they were too busy. During an interview on 4/6/2025 at 11:25 AM, Resident #210 stated they had been a resident a long time, and most staff did a great job. Some of the staff were overworked and some did not seem to care about the residents. They stated recently the certified nurse aide caring for them took 2.5 hours to answer their call bell. They stated the certified nurse aides usually had 8 assigned residents and should stop in and see if everyone was alive and well or if they had any problems. During an interview on 4/6/2025 at 12:26 PM Resident #80 stated certified nurse aides yelled at residents and staff sat at the nurses' station using their cell phones. The last time the Department of Health was at the facility, they were told if they said anything they would get kicked out of the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/6/2025 at 1:20 PM, Resident #94 stated the residents were disrespected. If they asked for something they would get the runaround or staff just would not do it. Some of the staff were rude and nasty to the residents. They stated they felt they were singled out on many occasions and yesterday the certified nurse aide who delivered their meal tray just threw the tray down and slammed the door. During an interview on 4/7/2025 at 7:21 AM Resident #70 stated staff ignored their call bell, so they had to wait and wait and holler to get anyone to help them. During an interview on 4/7/2025 at 8:37 AM, Resident #376 stated there was a 2-hour call bell wait time. There was no supervision on weekends, and they called it the weekend [expletive] show. They had told the Administrator who responded, what do you want me to do?. The resident stated their response to the Administrator was to get rid of cell phones. There was a lot of agency staff, and it took forever to get someone. Sometimes there was only one Supervisor, and they had to pass medications because someone did not come in. During a Resident Council meeting on 4/7/2025 at 11:17 AM residents unanimously stated they were afraid to complain as they feared nursing staff would retaliate and be [NAME] and yell at them. They agreed when they put their call bells on either no one answered, staff turned them off, or staff answered and said they had to get the resident's assigned staff and then never come back. Several residents stated they called the ward clerk to tell them they needed help. The ward clerk's response was often stop calling the desk. Residents stated they felt disrespected because staff did not answer the call bells. They stated they observed evening and overnight shift staff sleeping in the shower room or break room. During an interview on 4/8/2025 at 10:34 PM, Resident #94 stated staff were rude, and it was very hurtful to see staff given rewards for poor treatment. The chart in the lobby displayed things that staff had won, but when you read the names, they were staff that treated residents poorly. The following observations were made of the 3rd floor: - on 4/8/2025 at 9:26 PM Certified Nurse Aide #175 was at the desk scrolling on their phone with an ear bud in. An unidentified certified nurse aide approached Certified Nurse Aide #175 and asked them for help with a resident. Certified Nurse Aide #175 did not respond. After several more requests for help, Certified Nurse Aide #175 told the unidentified certified nurse aide to wait a minute because they were ordering something. - on 4/8/2025 at 9:33 PM an unidentified certified nurse aide was on their phone at the nurses' station while five residents were sitting in chairs across from the nurses' station. There was interaction between the certified nurse aide and the residents. The following observations were made of the 4th floor: - on 4/6/2025 at 9:45 AM three residents were in the dining room unattended, and an unidentified staff member was on their cell phone. - on 4/6/2025 at 12:57 PM, Certified Nurse Aide #172 was in the dining room on their cell phone. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 4/6/2025 at 2:35 PM, two unidentified certified nurse aides were sitting and talking at the nurses' station while room [ROOM NUMBER] had an active call light on. - on 4/7/2025 from 6:18 AM to 7:00 AM, two unidentified certified nurse aides remained in the breakroom on their phones until they put their coats on and departed the unit for the end of their shift. - on 4/8/2025 at 9:09 AM, Certified Nurse Aide #51 was observed with earbuds in both ears. - on 4/8/2025 at 9:21 AM, an unidentified certified nurse aide told Licensed Practical Nurse #21 to turn off Resident #170's call light because they were in the dining room. Licensed Practical Nurse #21 went to the resident's room and turned off the call light without asking the resident what they needed. Resident #170 stated they turned on the call light because they needed the bedpan and was upset staff left without putting them on the bedpan or asking what they needed. - on 4/8/2025 at 12:49 PM two unidentified certified nurse aides were in the dining room on their cellphones. - on 4/9/2025 at 12:39 PM Certified Nurse Aide #172 was in the dining room with an ear bud in their left ear. - on 4/9/2025 at 12:40 PM Licensed Practical Nurse #21 walked through the dining room with earbuds in both ears. - on 4/18/2025 at 12:20 PM Certified Nurse Aide #51 was in the 4th floor dining room on their phone eating Chinese food. The following observations were made of the 6th floor: - on 4/6/2025 at 10:12 AM Certified Nurse Aide #79 silenced a call light tone at the nurses' station. - on 4/6/2025 at 10:16 AM Certified Nurse Aide #79 silenced a call light tone at the nurses' station. - on 4/6/2025 at 12:34 PM unidentified staff were arguing loudly in the area behind the nurses' station and other staff intervened to calm the situation. - on 4/7/2025 at 9:49 AM an unidentified certified nurse aide and an unknown dietary aide were on their phones in the dining room. - on 4/7/2025 at 6:42 AM a call bell was ringing with Certified Nurse Aide #176 sitting at the desk with 2 earbuds in and playing on their phone. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 4/8/2025 at 11:28 PM room [ROOM NUMBER]'s call light was on and the call bell system phone at the nurses' station documented it had been on for 31 minutes and 50 seconds. At 11:30 PM an unidentified nurse entered the room, the resident asked for their tramadol, the nurse stated they would see what they could get them and turned the call light off. At 11:45 PM the resident had not received their medication. - on 4/9/2025 at 11:46 AM room [ROOM NUMBER]'s call light was going off and the call light system phone showed it had been on for 20 minutes and 13 seconds. - on 4/9/2025 at 12:23 PM Certified Nurse Aide #177 was sitting on a side table using their personal phone while a resident was eating, and the tray line was in progress. - on 4/15/2025 at 9:09 AM [NAME] Clerk #111 silenced room [ROOM NUMBER]W's call light at the nurses' station. The following observations were made of the 7th floor: -on 4/8/2025 at 10:02 PM, a call bell was on while an unidentified certified nurse aide was on their phone in the pod near the common area. Staff Interviews: During an interview on 4/8/2025 at 1:05 PM, Residents Dining Experience Manager #99 stated staff ate fast food in front of the residents, and they saw staff on their phones all the time. It was against the rules to have electronic devices on the units. During an interview on 4/9/2025 at 11:19 AM, Certified Nurse Aide #51 stated they had enough staff when the Department of Health was there. The staff did hang out in the breakroom, and sometimes had more down time. Staff ate outside food in the dining room in front of the residents. They felt bad, but did not know what they could do about it. They were not allowed to wear earbuds, because they might not be able to hear a resident or the call bell. They had worn them earlier in the week during the survey but took them out. During an interview on 4/9/2025 at 11:48 AM, Licensed Practical Nurse #52 stated they saw certified nurse aides and nurses sitting in the break room for extended periods of time. They could tell them to leave the break room, but they were not listened to and did not want to get targeted. They heard certified nurse aides be rude to residents by either yelling at them or ignoring them. Earbuds were not allowed because staff might not hear a fall, a call bell, or someone yell. They saw staff wearing earbuds and told Licensed Practical Nurse Unit Manager #40. Staff were not allowed to have cell phones out in resident areas, and they saw staff with their phones and asked them to put them away, but some did not listen. During an interview on 4/15/2025 at 12:13 PM, Certified Nurse Aide #54 stated if staff were in the core they were supposed to stay in the core (common area/dining area) but staff that were not in the core were supposed to answer all lights even if the resident was not on their assignment. They witnessed staff tell residents their assigned certified nurse aide was in the core area and could not assist the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/2025 at 11:56 AM, Licensed Practical Nurse #21 stated earlier during the survey they turned Resident #170's call bell off when staff told them to turn it off because their certified nurse aide was in the core. The resident had not told them what they needed but usually needed the bedpan. The certified nurse aide on the floor was not able to answer the bell because most of the staff were in the core. There were not enough staff to answer call bells during the core times. During an interview on 4/18/2025 at 10:38 AM, Licensed Practical Nurse #130 stated earbuds were not allowed and if they saw staff using them, they told them to go in the breakroom. They noticed certified nurse aides sitting in the break room but assumed they were on their break and that care was complete. They usually took a break at 10:00 AM and returned at 11:00 AM. They were unsure how long their break was supposed to be, but staff got two 15 minute breaks and a 30 minute break. During an interview on 4/18/2025 at 11:32 AM, Licensed Practical Nurse Unit Manager #40 stated staff were not supposed to be on cell phones when on the floor or in the dining room. It could be seen as disrespectful and sometimes they were swearing or yelling or using inappropriate language. Licensed practical nurses should tell certified nurse aides to get off their phones and put them away. Earbuds should not be worn because that was disrespectful. They saw staff with earbuds and phones and told them to put them away. It was rude to residents. Staff got a 15-minute break and a 30-minute lunch break, and they could not take their breaks when residents were eating. During an interview on 4/18/2025 at 1:44 PM, the Director of Nursing stated they combatted earbuds. Staff were not supposed to have them or cell phones because of Health Insurance Portability and Accountability Act concerns (resident privacy). It could make residents feel not heard. Staff were not allowed to eat when the residents were eating, and they did not expect staff to be in break rooms as they should be caring for the residents. 415.11(c)(3)(i)

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	04/18/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48446 Based on observations, record review, and interviews during the recertification and abbreviated (NY00374160) surveys conducted 4/6/2025-4/18/2025, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two (2) of five (5) residents (Residents #160 and #336) reviewed. Specifically, Residents #160 and #336 were not provided with oral hygiene or hair care. Findings include: The facility policy Hygiene/Grooming, revised 3/2023, documented personal hygiene, skin integrity, personal dignity, and a feeling of well-being was maintained for each resident. Residents requiring assistance with activities of daily living received a partial bed bath daily. Residents were provided the opportunity for a bed bath, shower, or whirlpool once a week unless otherwise indicated in their plan of care. Resident hygiene included hair care, nail care, foot care, and mouth care. 1) Resident #160 had diagnoses including morbid obesity, major depressive disorder, and diabetes. The 2/6/2025 Minimum Data Set assessment documented the resident had intact cognition, no behavioral symptoms, did not reject care, and was dependent on one for most activities of daily living. The Comprehensive Care Plan initiated 1/21/2020 and revised 4/6/2025, documented the resident had alterations in activities of daily living function related to a mobility deficit, decreased muscle strength, general deconditioning, and chronic respiratory failure. Interventions included shampooing hair with showers or as desired by the resident and oral care with partial/moderate assistance of one. The resident's care instructions (Kardex) documented the resident required partial or moderate assistance with oral hygiene and was dependent on staff for hygiene needs. Resident #160 was observed at the following times: - on 4/7/2025 at 9:08 AM with uncombed, matted, greasy hair. The resident had foul breath. - on 4/8/2025 at 9:10 AM with uncombed, matted, greasy hair. The resident had foul breath. The resident stated they wanted their teeth brushed and only had to be set up with their electric toothbrush, but no one ever set them up. They resident stated they wanted their hair shampooed. - on 4/10/2025 at 1:13 PM with uncombed, matted, greasy hair. The resident had foul breath. The resident stated they did not get their shower on Fridays on the 3 PM-11 PM shift. They stated they got cellulitis from not being washed in months. They wanted to brush their teeth every day and was capable of doing it independently, however staff did not hand them their toothbrush, toothpaste, or a cup of water. They were afraid to ask for their toothbrush because they thought staff would retaliate against them. They stated many of their teeth fell out since being at the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident #336 had diagnoses including morbid obesity, depression, and heart failure. The 3/8/2025 Minimum Data Set assessment documented the resident had intact cognition, had no behavioral symptoms, did not reject care, and was dependent on one for most activities of daily living. The section for oral/dental status was not completed. The Comprehensive Care Plan, initiated 7/1/2024 and revised 4/14/2025, documented the resident had an alteration in activities of daily living function related to a mobility deficit and decreased muscle strength. Interventions included showers every Tuesday day shift and the resident was dependent on staff for hygiene and oral care. The resident's care instructions (Kardex) documented the resident was dependent on one for showers, showers were scheduled on Tuesdays during the day shift, the resident had their own upper and lower teeth and required total assistance of one staff with oral hygiene. The 7/18/2024 dental consultation report documented the resident did not have upper teeth. Resident #336 was observed: - on 4/6/2025 at 10:05 AM in bed with no upper teeth, several missing bottom teeth, a foul breath odor, and long uncombed, tangled hair. - on 4/8/2025 at 9:40 AM in bed with no upper teeth, several missing bottom teeth, a foul breath odor, and long uncombed, tangled hair on - on 4/9/2025 at 9:17 AM in bed with no upper teeth, several missing bottom teeth, a foul breath odor, and long uncombed, tangled hair. The resident stated their shower day was 4/8/2025 and a certified nurse aide told them they would wash them up and get them out of bed at 1:00 PM yesterday afternoon and they never did. They did not know the name of the staff member because they were not wearing a badge or had the badge turned over, so their name was not seen. They wanted to get washed and had been asking for a haircut for several weeks. Two different times a barber came to their room and said they would come back to cut their hair and never did. The certified nurse aide activities of daily living log documented the resident was bathed on 4/2/2025 and 4/9/2025 during the day shift by Certified Nurse Aide #54. During an interview on 4/9/2025 at 11:48 AM, Licensed Practical Nurse #52 stated certified nurse aides were responsible for grooming residents. Residents were showered weekly, and the shower date was listed on the assignment sheet. It was important to brush resident's teeth, so they did not lose their teeth. Resident #336 had long hair and if it was not brushed it could become matted. If hygiene needs were not met the residents could get sick. It was also a dignity issue. During an interview on 4/17/2025 at 2:35 PM, Certified Nurse Aide #54 stated they completed all morning care which included showering, washing, oral care, combing hair, and shaving. Resident #336asked for a haircut several months ago and they notified the barber. They did not comb Resident #336 hair or provide oral care to the resident today and should have. When they are in the Core (dining room) they are not able to provide care to residents and did not always have time to complete their assignments. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/18/2025 at 11:32 AM, Licensed Practical Nurse Unit Manager #40 stated certified nurse aides were responsible for resident care which included get dressed, washed, and out of bed for the day. Some staff did a better job that others and rotated the assignment to keep them fair. When the care was completed, it was documented in the computer as completed. If a resident refused care, they were notified and documented the refusal in a nursing progress note. Hair should not be matted, and a shower cap should be used at least once a week. Approximately two weeks ago a barber came to Resident #336 to cut their hair and was going to come back the following day and did not. They did not follow up with the barber and should have. It was a resident right to be groomed properly. During an interview on 4/18/2025 at 12:21 PM, Certified Nurse Aide #173 stated Resident #336 asked for a haircut at least two months ago when the resident was on their assignment. The back of their hair was so matted they were not able to comb through it. They stated the barber came into the resident's room about two months ago and said they would be back and did not return. If a resident wanted to be groomed and was not it could be a dignity issue. During an interview on 4/18/2025 at 1:44 PM, the Director of Nursing stated activities of daily living care should be provided according to the care plan and resident preference. Hair should be brushed, and oral care should be done every day unless a resident refused. If hair and teeth were not brushed or showers not provided it could make the resident feel down. During an interview on 4/15/2025 at 12:29 PM, Certified Nurse Aide #169 stated they were responsible for providing care to residents including bathing, showering, feeding, dressing, hair care, and oral care. A lot of staff did not provide oral care because they lost track of it over the years. They completed all care for their assigned residents for the day and included brushing hair and teeth. They were assigned to Resident #160 and brushed their hair and teeth. The resident had intact cognition and did not refuse care. They threw away the toothbrush they used and was unable to locate the hairbrush. They stated the tangled mat of hair on Resident #160 was worse before when they had to cut out the chunk of hair because it could not be combed through. Resident #160 stated they did not have their teeth brushed and showed the certified nurse aide their electric toothbrush. Certified Nurse Aide #169 stated they were not sure why they did not wash the resident's hair or comb it. 10 NYCRR 415.12(a)(3)

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	04/18/2025

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 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** 48052 50561 Based on observations, record review, and interviews during the recertification and abbreviated (NY00325460) surveys conducted 4/6/2025 - 4/18/2025, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for two (2) of three (3) residents reviewed (Residents #274 and #461). Specifically, Resident #274 was not provided a wound vacuum machine (vacuum assisted closure using negative pressure to assist in wound healing) or the back-up wet to dry dressing treatment as ordered; and Resident #461 did not receive timely follow-up care for their dehisced wound (a surgical incision that reopens) This resulted in harm to Resident #461 that was not Immediate Jeopardy. Findings include: The facility policy Change in Resident Condition, reviewed 12/2022, documented the nursing supervisor would notify the medical provider when there was a change in the resident's condition. All physician's or practitioner's orders would be followed. The nursing supervisor was to notify the resident of any changes in their condition or medical care. The facility policy Negative Pressure Wound Therapy, revised 3/12/2019, documented any resident who has an ulcer would receive care and services to promote healing to include, when needed, negative pressure wound therapy (wound vacuum). Responsible parties include licensed practical nurses and registered nurses who have been trained and have demonstrated competency may apply, change, or remove negative pressure wound dressings. 1) Resident #461 had diagnoses including peripheral vascular disease (poor blood flow) and right above the knee amputation. The 1/26/2025 Minimum Data Set documented the resident had intact cognition and did not have surgical wounds at the time of the assessment. The resident was hospitalized [DATE] - 3/11/2025 for acute lower limb ischemia (lack of blood flow) and underwent a right above the knee amputation. The 3/11/2025 physician's order documented apply abdominal gauze pad to right above the knee amputation surgical site and wrap with kerlix every Tuesday and Friday during the day shift and as needed. The 3/27/2025 Registered Nurse Unit Manager #9 progress note documented the resident returned from their post-operative follow up appointment following a right above the knee amputation. The consult documented the resident did not have significant pain, the stump was soft and nontender, the incision line was intact with the sutures in place without drainage. The incision had necrosis (dead tissue) but was dry. The resident was to return in two (2) to three (3) weeks for suture removal. The incision was to be covered daily. The follow-up appointment was scheduled for 4/15/2025 at 10:15 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	The 4/4/2025 Licensed Practical Nurse Assistant Unit Manager #7 progress note documented the right above the knee amputation site sutures appeared to have come undone on the inner left side. The dehisced area appeared red with white drainage around the area. The resident had pain to the dehisced area. The nurse practitioner saw the resident and gave new orders for an antibiotic and requested a vascular consult. The 4/4/2025 Nurse Practitioner #48 progress note documented they were following up on a possible wound infection. Staff was giving the resident a shower and noticed the stitches had come out of the right above the knee amputation site. The area looked infected, a couple of sutures came out and an area of the incision had dehisced. The area had redness, pus filled drainage, was warm, and painful. The resident was started on an antibiotic twice a day for seven days. They directed nursing to call and try to get the resident back into the vascular consultant as soon as possible. There was no documented evidence the vascular consultant was contacted for an appointment for surgical wound follow up. During an observation and interview on 4/6/2025 at 11:55 AM, the resident stated they were concerned their right above the knee amputation was opening. The surgical incision was dehisced about two (2) or more inches. The above the knee amputation surgical site was mid/upper thigh. Inside the wound was a whitish, flesh colored lump. The resident stated they had pain, and it had been open for more than two (2) days. The resident's incontinence brief was positioned next to the wound at the upper thigh and had brownish red fluid on the side. The resident's bed sheets also had a brownish red fluid. At 11:57 AM, [NAME] Clerk #88 entered the resident's room and stated they would get someone to look at the resident's surgical site. [NAME] Clerk #88 left the room and came back at 12:02 PM. They asked the resident what happened, and the resident stated their incision site was broken open. At 4:46 PM, the resident had two overlapping pink adhesive bandages over the entire end of their stump and the blankets under resident had dried reddish-brown spots. The 4/6/2025 Registered Nurse Unit Manager #9 progress note documented the resident had an unwitnessed fall in their room. The resident had right above the knee amputation dehiscence with no drainage noted. The resident was on antibiotics and a dressing was applied. The resident denied pain or discomfort. The on-call providers were notified. There was no documented evidence of a planned vascular consultant follow-up. I The 4/7/2025 Registered Nurse Unit Manager #9 progress note documented the resident was seen during rounds by the attending nurse practitioner for respiratory symptoms. There was no documentation regarding the resident's surgical wound dehiscence. The 4/7/2025 progress notes by Licensed Practical Nurse #170 documented they were notified by Licensed Practical Nurse Assistant Unit Manager #7 resident had a fall at 8:30 PM on 4/6/2025. The resident's sutures to their right above the knee amputation had come undone and the resident's bone was protruding. The unit nurse provided wound care. The physician was called and ordered the resident to be sent to the Emergency Department. The resident was hospitalized from 4/7/2025 - 4/11/2025 for post-operative infection and wound dehiscence. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/9/2025 at 10:49 AM, [NAME] Clerk #88 stated they took care of all the appointments for the residents on the unit. If a provider wanted a resident to see an outside provider sooner than what their scheduled appointment was, there would be a consult order in the electronic medical record. They stated they reviewed every resident's chart every day for new consult orders. If a provider ordered a resident to be seen by vascular as soon as possible on a Friday afternoon, the nurse practitioner informed Registered Nurse Unit Manager #9 or Licensed Practical Nurse Assistant Unit Manager #7. The information was passed to them, and they would call the vascular provider. Resident #461 had a vascular appointment scheduled for 4/15/2025 at 10:00 AM and they informed Registered Nurse Unit Manager #9 on 4/4/2025 when they asked about an appointment. They were not asked to schedule the appointment sooner. During an interview on 4/16/2025 at 11:26 AM, Licensed Practical Nurse #17 stated they were informed on 4/6/2025 that Resident #461's surgical incision had opened more. They applied a dry dressing on the surgical incision site early in the morning as the resident's dressing had fallen off. They noted the incision was open about an inch. After the resident's second fall on 4/6/2025, they observed the surgical incision was open about 3 to 4 inches and put a foam dressing on it. During an interview on 4/17/2025 at 12:50 PM, Licensed Practical Nurse Assistant Unit Manager #7 stated when they saw Resident #461's surgical incision on 4/4/2025, the first one (1) to two (2) sutures had come undone and there was some drainage. They called Nurse Practitioner #48 to assess the resident. Nurse Practitioner #48 ordered Bactrim for cellulitis (a bacterial infection) and wanted a vascular consult as soon as possible which meant within the next day or so. If a resident needed an appointment scheduled as soon as possible the nurse or medical provider put in an order for the appointment to be scheduled as soon as possible by the ward clerk. They were unsure if the vascular consult was called for Resident #461 on 4/4/2025. They stated an appointment on 4/15/2025 would not be considered as soon as possible. During an interview on 4/17/2025 at 1:31 PM, Registered Nurse Unit Manager #9 stated if a provider saw a resident and stated they needed a follow up as soon as possible, the ward clerk should call the outside provider to schedule an appointment. They stated if they were unable to get an appointment scheduled, they should notify the nurse practitioner to find out the next steps. During an interview on 4/17/2025 at 1:58 PM, Nurse Practitioner #48 stated they saw Resident #461 on 4/4/2025 for their surgical incision opening. The wound was open two (2) to three (3) centimeters. They stated they started the resident on antibiotics for cellulitis and wanted the resident seen by vascular as soon as possible. They were informed the resident was going to be seen on 4/15/2025 but had instructed the nursing staff to try again as that was too long to wait for the resident to be seen. They stated if they had been informed it had opened to 3 - 4 inches with drainage, they would have sent the resident to the hospital. 2) Resident # 274 had diagnoses including osteomyelitis (bone infection) of the left foot, left toe amputations, and diabetes. The 2/4/2025 Minimum Data Set Assessment documented the resident had intact cognition, was independent with most activities of daily living, had a surgical wound, and received surgical wound care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	The Comprehensive Care Plan initiated 1/11/2025 documented the resident had surgical debridement (removal of dead tissue) of the left foot. Interventions included provide wound care as ordered; observe for effectiveness of treatment; wound vacuum-assisted closure; weekly skin evaluations by registered nurse; and monitor for pain prior to dressing change. Physician orders documented: - On 11/14/2024, wet-to-dry dressing as backup if wound vacuum malfunctions or cannot restore vacuum in 24 hours, as needed. - On 11/29/2024, continuous negative pressure wound therapy to left trans metatarsal amputation (removal of toe) open site every day during the day shift. - On 11/29/2024, dressing type: black foam, change wound vacuum dressing every Monday, Wednesday, and Friday; pack 5th toe amputation site with Aquacel Ag (antimicrobial wound dressing) and cover with black foam, three (3) times a week on Monday, Wednesday, and Friday during day shift. - 11/29/2024 change canister and canister tubing (of wound vacuum) weekly on Wednesday day shift. The 1/17/2025 Physician #3 progress note documented the resident had wound vacuum-assisted closure changes three times a week, and recent wound pictures showed good granulation (new tissue). A 1/31/2025 Wound Care Clinic progress note documented the resident had a non-healing diabetic foot ulcer. The ulcer was worsening despite standardized wound care, off-loading, serial debridement (removal of dead tissue), and negative pressure wound therapy. The wound vacuum was not on during the visit. The resident was having issues with the wound vacuum being placed at the facility, the usual wound care nurse was out. The facility was working on finding someone who could replace the wound vacuum regularly as scheduled on Monday, Wednesday, and Friday. Otherwise, the wound appeared stable. A 2/5/2025 Wound Care Registered Nurse #128 progress note documented the surgical wound to the left foot measured 7.0 centimeters x 5.0 centimeters x 0.2 centimeters and had a large amount of drainage with no odor. The wound was pink in color with no signs of infection. The wound was cleaned, and treatment was applied. The 2/2025 Medication Administration Record documented the vacuum-assisted closure dressing was not changed from 2/6/2025 - 2/19/2025. There was no documented evidence of wet-to-dry dressing applied from 2/6/2025 - 2/19/2025 per orders for when the wound vacuum was not used. There were no documented nursing progress notes regarding the resident's wound or dressing from 2/6/2025 - 2/19/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	The 2/7/2025 Wound Care Clinic visit summary documented the resident had a non-healing diabetic foot ulcer. The ulcer was worsening despite standardized wound care, off-loading, serial debridement (removal of dead tissue), and negative pressure wound therapy. The resident was receiving adjunctive hyperbaric oxygen therapy to improve healing. The wound care instructions included wound vacuum to left foot, black foam, vacuum set to 125 millimeters of mercury, change Monday, Wednesday, and Friday. The 2/21/2025 Medical Director progress note documented the resident had a wound vacuum with dressing changes three times a week. There was no documented evidence the physician was notified of the wound vacuum not being applied. The 2/26/2025 Wound Care clinical communication documented the resident's wound was improving. During an observation and interview on 4/8/2025 at 9:57 AM, Resident #274 stated there was a time when the vacuum assisted closure device had been off for several days in February 2025, specifically during the time the wound nurse was out. They stated there was no one in the facility that was able to provide the care needed for the wound vacuum-assisted closure device. They stated during that time they wheeled around the hallway to find someone who was able to apply their wound vacuum. The resident stated they covered the wound with gauze and tape until the wound care nurse returned. The resident stated they relied heavily on Wound Care Registered Nurse #128, and they had never met the other wound care nurse. During an observation and interview on 4/9/2025 at 8:56 AM, Wound Care Registered Nurse #128 completed wound care and applied Resident #274's wound vacuum. The wound was dry without drainage or redness. Wound Care Registered Nurse #128 stated if the wound vacuum was to come off, a dressing would be put in place until the wound vacuum was able to be replaced. Wound Care Registered Nurse #128 stated in the event of their absence, the nursing supervisor, or the unit nurse would be responsible for applying the device. They stated they were off for 10 days between 2/6/2025 and 2/21/2025 and they expected Wound Care Registered Nurse #136 to monitor or consult for residents with specialized treatments such as Resident #274. Anyone who provided care for the resident was expected to document in the Medication Administration Record to indicate the treatment was done. They stated there was a lack of continuity of care during their absence. During an interview on 4/15/2025 at 11:11 AM, Registered Nurse Unit Manager #9 stated there was a gap in treatment documentation between 2/6/2025 and 2/21/2025 which indicated they forgot to document the wound care. They were confident the care was done; however, it was not documented. Registered Nurse Unit Manager #9 stated in the absence of the primary wound nurse, the other wound nurse should be responsible for changing the wound vacuum-assisted closure. During an interview on 4/16/2025 at 12:38 PM, the Director of Nursing stated all licensed practical nurses completed wound vacuum-assisted closure care competencies annually and were able to provide that care. When the wound team registered nurses were off, it was communicated to the licensed practical nurses they would be responsible for the treatments. They were not aware Resident #274's wound vacuum-assisted closure dressing had not been changed. The Medication Administration Record documented the dressing was on, but not that it was changed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/18/2025 at 9:30 AM, Licensed Practical Nurse #7 stated nursing staff failed to document the resident's wound care between the dates of 2/6/2025 and 2/21/2025. They stated adhering to a wound care plan was important because the resident was a diabetic and had already lost the top half of their foot and failure to follow physician orders for wound care could result in the wound not healing. During an interview on 4/18/2025 at 10:51 AM, Wound Care Registered Nurse #136 stated they had not provided wound care to Resident #274. They stated they were not responsible for covering the entire caseload of the other wound care nurse during their absence. 10NYCRR 415.12 51469

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	04/18/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49448 Based on observations, record review, and interviews during the recertification survey conducted 4/6/2025-4/18/2025, the facility did not ensure residents received care, consistent with professional standards of practice, to prevent pressure ulcers and promote healing of pressure ulcers for two (2) of three (3) residents (Residents #71 and #114) reviewed. Specifically, Resident #71's and #114's physician orders for alternating air mattresses (a specialty mattress providing air flow to relieve pressure) did not include individualized settings and the mattresses were not monitored to ensure appropriate settings for the resident's current weights. Findings include: The Alternating Air Mattress Manual documented it was recommended the pressure-selector knob was set to firm or pressed auto firm on the touch panel each time the mattress was first inflated. Thereafter the air mattress was easily adjusted to the desired firmness according to the patient's weight. 1) Resident #71 had diagnoses including left sided paralysis following a stroke. The 2/6/2025 Minimum Data Set assessment documented the resident was cognitively intact, dependent for bed mobility and transfers, was at risk for pressure ulcers, had a pressure reducing device for the bed, and weighed 117 pounds. The Comprehensive Care Plan, initiated 2/10/2025 and revised 4/16/2025, documented the resident was at risk for impaired skin integrity related to bed mobility/ bedfast, incontinence, and friction and shearing. Interventions included the use of an alternating air mattress. The 10/10/2024 Nurse Practitioner #48's order documented the resident was to have an alternating air mattress and an inflation and function check every shift. The order did not include settings for the mattress. The resident's weights documented: - on 3/19/2025 118.5 pounds. - on 4/14/2025 117.8 pounds. The following observations were made of Resident #71 lying on their back in bed with the alternating air mattress set at [PHONE NUMBER] pounds: - on 4/6/2025 at 10:41 AM - on 4/8/2025 at 8:54 AM - on 4/9/2025 at 9:12 AM - on 4/15/2025 at 9:30 AM, 11:27 AM and 12:27 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The April 2025 Treatment Administration Record documented alternating air mattress check inflation and function every shift. The air mattress was documented as checked for inflation and function every shift 4/6/2025- 4/15/2025 (except 4/8/2025 and 4/10/2025 day shifts, and 4/12/2025-4/13/2025 evening shifts). The Treatment Administration Record did not include the recommended mattress settings. 2) Resident #114 had diagnoses including a Stage 2 pressure ulcer (partial thickness skin loss) of left buttock and a Stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) of the buttocks. The 3/2/2025 Minimum Data Set assessment documented the resident was cognitively intact, required substantial/ maximum assistance with bed mobility and transfers, was frequently incontinent of bowel and bladder, did not have pressure ulcers, was at risk for pressure ulcers, and had a pressure reducing device for chair and bed. The Comprehensive Care Plan, initiated 3/10/2025 and revised 3/18/2025, documented the resident had impaired skin integrity following an incision and drainage (an incision to drain pus and fluids) of the sacrum (end of spine). Interventions included wound care as ordered and an alternating air mattress. The 2/24/2025 Nurse Practitioner #48's order documented the resident was to have an alternating air mattress and an inflation and function check every shift. The order did not include settings for the mattress. The 4/7/2025 Wound Care Nurse Practitioner #148 progress note documented the wound was assessed with improvement noted. Continue same treatment plan. The resident remained on a low air loss mattress. On 3/17/2025 Resident #114's weight was documented as 76.5 pounds. Resident #114 was observed lying on their back in bed with the alternating air mattress set at 420-pounds on 4/6/2025 at 10:19 AM, 4/8/2025 at 8:58 AM, and 4/15/2025 at 9:29 AM. The April 2025 Treatment Administration Record documented alternating air mattress, check for proper function and inflation every shift. The Treatment Administration Record documented the air mattress was checked for function and inflation every shift 4/6/2025-4/15/2025 except for the evening shift on 4/13/2025. The Treatment Administration Record did not include the recommended mattress settings. During an interview on 4/15/2025 at 10:11 AM, Certified Nurse Aide #152 stated some residents had air mattresses and the only thing they did with them was call maintenance if the pump was alarming. During an interview on 4/15/2025 at 12:28 PM, Licensed Practical Nurse #151 stated they did not have any responsibility related to the air mattresses. They did not know which residents had air mattresses and would only know if they saw the machine at the foot of their bed. There were no routine checks of air mattresses and if the machine alarmed, it meant it was not working properly and they would call central supply. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/2025 at 10:04 AM, Licensed Practical Nurse Assistant Unit Manager #149 stated the wound registered nurse determined if a resident needed an air mattress. Central supply set up the mattress to include setting the mattress to the correct weight. Resident #114's mattress was set at 420 pounds and Resident #71's mattress was set to [PHONE NUMBER] pounds; both were not appropriate settings for their weights. They did not know much about air mattresses but thought if there was a weight setting that meant the mattress should be set to the resident's weight. The point of the air mattress was for support, pressure alleviation, and prevention of further worsening of wounds and inappropriate settings could cause worsening wounds. Resident #71 did not have a wound and Resident #114's wound had stayed about the same. They stated nursing did not check the mattresses and if the mattresses were not checked, there was no way of knowing if the mattresses were set appropriately. During an interview on 4/16/2025 at 11:14 AM, the Director of Central Supply #150 stated the wound nurses put in a work order if they needed an air mattress set up. The air mattresses were set up based on the resident's weight which was obtained by asking a certified nurse aide or the Nurse Manager. From there, the wound nurses made sure it was set appropriately, and the weight setting was accurate. During an interview on 4/17/2025 at 11:06 AM, the Assistant Director of Nursing #47 stated air mattress checks were documented on the Treatment Administration Record. Checks consisted of checking to make sure the mattress was on and functioning and did not include checking the settings. Before yesterday, they had not realized the air mattresses had a weight setting. Resident #114 was followed by the wound team and did not weigh 420 pounds. Resident #71 did not have a pressure wound but was at risk to develop one. Resident #71was tiny and not [PHONE NUMBER] pounds. They thought the weight setting should be checked to ensure the mattress was effective. It if was not set at the appropriate weight it was not at the right pressure and defeated the purpose of the mattress. During an interview on 4/18/2025 at 9:39 AM, Wound Registered Nurse #136 stated there was an order to check air mattress inflation and function every shift once central supply installed the mattress. The air mattresses were regulated by body weight. They double checked the settings after central supply installed the mattress. If the setting was too low, it would not work and if it was too high it could cause harm. Resident #114 had a sacral wound which was staying about the same. Resident #71 had limited mobility in bed and was at risk for a pressure wound. If their air mattresses were inappropriately set it could increase the chances of Resident #71 getting a wound and increase Resident #114's chance of their wound worsening. The nurses were signing off on the Treatment Administration Record for inflation and function. The appropriate weight setting was part of checking function and if it was signed off, it should have been checked. 10NYCRR 415.12(c)(1)

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	04/18/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48052 48446 Based on observations, record review, and interviews during the recertification survey conducted 4/6/2025-4/18/2025, the facility did not ensure residents received adequate supervision to prevent accidents for 4 of 6 residents (Residents #27, #167, #274, and #419) reviewed. Specifically, Resident #27 had an order not to receive straws due to oral phase dysphagia (difficulty swallowing) and was observed using straws; Resident #167 had medications left at their bedside; Resident #274 had a used needle and vacuum from a blood draw disposed of in the trash can in their room; and Resident #419 sustained a burn after using a microwave independently to heat food. Findings include: The facility policy Standard Precautions, revised 6/2019, documented used disposable needles would be placed in appropriate puncture-resistant containers located as close as practical to the area in which the items were used. The facility policy, Reheating of foods, effective 1/8/2020 documented food would be reheated to appropriate temperatures for resident satisfaction and to ensure food safety by staff members. A digital probe thermometer was used to check the temperature of foods and beverages not to exceed a temperature of 165 degrees Fahrenheit. The facility policy, Medication Administration Policy and Procedure, revised 11/2021 documented all residents should be given the right medication, the right dose, the right time, using the right method with the right method of documentation. Medications were never to be left in a resident's room. Needles were always disposed of in a sharp's container. The facility policy, Comprehensive Nutrition Assessment, reviewed 9/2023 documented therapists (including the speech language pathologist) identified concerns related to feeding ability, mobility, and swallowing, and tailored interventions accordingly. 1) Resident #27 had diagnoses including dysphagia (difficulty swallowing), dementia, and cough. The 2/4/2025 Minimum Data Set assessment documented the resident had severely impaired cognition, did not have behavioral symptoms, and was independent with eating. The 2/12/2025 Speech Language Pathologist #34 evaluation documented the resident had moderate symptoms of dysphagia. The resident had immediate and delayed coughing while sipping liquid with a straw. The recommendations included thin liquids, and no straws, nursing and nutrition made aware. The 2/13/2025 physician order documented thin regular liquids and no straws. The 2/14/2025, comprehensive care plan documented the resident had dysphagia. Interventions included regular diet, ground solids, and thin liquids with no straws. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The undated care instructions documented the resident was a on a regular diet, ground consistency, no straws and assist the resident with set up of meals. The following observations were made of Resident #27 in their room: - On 4/7/2025 at 9:10 AM, sitting up in their wheelchair with a tray table in front of them. They were coughing, there were three pink straws on the bedside table and their breakfast meal ticket documented no straws. They were finished with breakfast. The resident stated the straws were for their drinks and came from the facility. - On 4/8/2025 at 12:47 PM, sitting up in their wheelchair with the tray table in front of them. The resident stated they were waiting for lunch. There were two pink and one blue straw on the bedside tray table. At 1:41 PM, they were drinking their ginger ale with a pink straw, about one third of the ginger ale had been consumed. One pink straw and one blue straw were next to the lunch tray. At 2:09 PM, there were two pink straws and one blue straw on the bedside table. - On 4/9/2025 at 9:22 AM and 12:46 PM there were three pink straws on the bedside tray table in front of the resident. - On 4/15/2025 at 11:06 AM, there was one pink straw, one blue straw, and one orange straw on the bedside table. The resident stated they did not know where the straws came from. During an interview on 4/15/2025 at 11:11 AM, Certified Nurse Aide #114 stated Resident #27was not allowed to have straws. When the resident used straws, they did not keep things down and would throw up. They had not noticed any straws in the resident's room today. The resident could independently place a straw in their drink, but they were not supposed to have them. Resident #27 was on their normal assignment, and they did not know where the straws kept coming. During an interview on 4/17/2025 at 10:21 AM, Licensed Practical Nurse Assistant Unit Manager #46 stated if a resident was not supposed to have straws it was on their meal ticket but also on their care card. Resident #27 was not supposed to have straws because they had difficulty swallowing. If the resident used straws, they were at risk to aspirate (inhale fluid into their lungs) and get pneumonia. If staff saw straws in their room, they should immediately remove the straws and report to a nurse. During an interview on 4/17/2025 at 11:19 AM, Assistant Director of Nursing #47 stated Resident #27 frequently had straws, but staff should be taking them away. The resident was not to use straws per speech recommendation, and they could aspirate if they used them. Their roommate might be giving them the straws but either way, they needed to be taken away. During an interview on 4/17/2025 at 2:19 PM, Speech Language Pathologist #34 stated they made the recommendations for no straws and if there was an order from the medical provider it was expected to be followed. Staff should take the straws away. Resident #27 was recommended to have no straws because they demonstrated the liquid was going in or around their airway so they could not safely use straws to drink. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Resident #274 had a diagnosis of osteomyelitis (bone infection). The 2/4/2025 Minimum Data Set assessment documented the resident had intact cognition and was independent with most activities of daily living. The 4/8/2025 lab report documented the resident had a blood specimen collected on 4/8/2025 in the morning. During an observation on 4/8/2025 at 8:46 AM, there was a lab draw needle connected to a vacutainer and a blue tourniquet in the trash can Resident # 274's room. Blood was present in the tubing. The resident stated they had bloodwork done earlier that morning. During an interview on 4/8/2025 at 9:19 AM, Licensed Practical Nurse #7 stated they drew the resident's blood for labs that morning. They stated needles and the vacutainer used for blood draws should be placed in a sharps container after use and they should not have tossed it into the trash can. They should have put the needle and the vacutainer in the sharp's container, however they were rushed and tossed the needle in the trash. The stated not placing sharps in the proper container could result in someone accidentally getting a needle poke which could lead to a transmission of a blood borne pathogen. The sharps containers were located on each medication cart. During an interview on 4/18/2025 at 9:15 AM, Housekeeper #82 stated if they observed a needle in a garbage can, they would put the garbage can on the table and mark it with a pen or marker and alert the nurse. When someone did not dispose of sharps correctly it could cause an accident such as a needle stick. During an interview on 4/18/2025 at 2:07 PM, Infection Control Nurse #104 stated blood draw needles and vacutainer should be disposed of in a sharp's container. It was not appropriate for any sharp to be discarded in the regular trash. There was a potential for the spread of infection, bloodborne pathogens, and risk of injury to other residents. 3) Resident #419 had diagnoses including left side paralysis following a stroke, chronic obstructive pulmonary disease, and diabetes. The 2/6/2025 Minimum Data Set documented the resident was cognitively intact, had no behavioral symptoms, utilized a wheelchair, and required supervision or was independent with most activities of daily living. The resident's Comprehensive Care Plan did not document the resident's ability to safely heat up or cook foods in a microwave oven. The 3/15/2025 Licensed Practical Nurse Assistant Unit Manager #7 progress note documented they were called to the unit due to Resident #419 stating they had burned themselves accidentally. They interviewed the resident who stated they were pouring hot water out in their bathroom sink when it slipped out of their hands and splashed on them. The resident had small superficial burns that blistered on their lower abdomen as well as the upper inner thigh. The resident stated that it was an accident, and they denied pain. They notified the on-call providers and were awaiting return call. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 3/17/2025 Nurse Practitioner #48 documented the resident had a small burn to their thigh that occurred when they were taking something out of the microwave and it spilled on them which caused the burn. The resident had told staff they were pouring hot water in their sink, and it splashed on them. The resident denied pain and there were no signs on infection. The orders documented were to continue to monitor the superficial burn to the left thigh. The facility 3/15/2025 Incident/Accident report documented: - The supervisor was called to the floor related to the resident stating they had burned themselves with hot water at 5:45 PM. - Resident #419's verbal statement transcribed by Licensed Practical Nurse Assistant Unit Manager #7 documented they were pouring hot water out in the bathroom sink when it slipped out of their hands and spilled on them. - Certified Nurse Aide #161's statement documented at 5:35 PM, they were sitting at the nurses' station when the resident was in the staff breakroom behind the nurses' stations heating up their food in the microwave. They overheard the resident laugh about burning themselves. - Licensed Practical Nurse #6's statement documented they were asked by the resident to heat up their food. They put the resident's food in the microwave in the breakroom. They walked away and when they made it back by the nurses' station, the resident was wheeling out of the breakroom with their food and stated they burned themselves. - Certified Nurse Aide #162's statement document they walked into the breakroom as the resident was rolling out in their wheelchair laughing about how they had burned themselves getting their food out of the microwave. The resident stated they were okay when asked. - The summary of the incident documented the incident was determined to be self-inflicted while removing their food from the microwave without staff assistance. The facility determined this was not reportable to the New York State Department of Health. During an observation and interview with the resident on 4/8/2025 at 2:07 PM, Resident #419 stated they had wanted ground turkey in the microwave in hot water for their spaghetti, as was their normal routine, and Licensed Practical Nurse #6 informed them they were not allowed to use the microwave behind the nurses' station anymore. The nurse heated up their meat for them and then gave back the bowl with the water and the meat. The resident stated they were straining it in their bathroom in their room when the bowl slipped and splashed hot water on them. The resident did not have care plan related to their continuous attempts to use the staff breakroom microwave behind the nurses' station on the unit. During an interview on 4/10/2025 at 9:09 AM, Certified Nurse Aide #114 stated resident food brought in from the outside was stored in both the staff breakroom fridge behind the nurses' station and in the core (the main dining room area). The unit had two microwaves, one in the staff breakroom and one in the core. Residents had access to the microwave in the core with supervision only as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/10/2025 at 9:16 AM, Licensed Practical Nurse #6 stated the microwaves on the unit were in the core and in the breakroom. Residents did have access to the microwave in the core, but it was too high up for most residents to reach. They used the breakroom microwave to heat Resident #419's food for them and the resident had wheeled their wheelchair into the breakroom and removed the food from the microwave themselves. The resident had laughed when coming out of the breakroom and stated they had got burnt removing their food from the microwave. They let the supervisor know about the burn and took the resident's vitals. They had utilized the staff breakroom microwave because it was the closest microwave to heat the resident's food. They stated the resident had a habit of attempting to use the staff breakroom microwave themselves, especially if there was new staff who didn't know them, which is why they had stopped the resident and heated it for them. During an interview on 4/10/2025 at 9:22 AM, Licensed Practical Nurse Assistant Unit Manager #7 stated the procedure for heating a resident's food was to heat it in the microwave in the core and then test the temperature by piece of the food on the back of the hand or with a gloved hand; if it was too hot to you, it would be too hot for the resident. They were one of the supervisors on duty when Resident #419 had gotten burned. They had come to the unit when they were notified and observed the resident had bubble blisters on the left thigh and left side of their abdomen but reported no pain. They informed the Register Nurse Supervisor, the Director of Nursing and the on-call medical providers. When they didn't receive a response from the on-call providers, they informed Nurse Practitioner #48 and described the burn to them. The resident did have a behavior of coming into the breakroom to heat their food and had been told previously they could not heat their food in the breakroom. During an interview on 4/10/2025 at 11:47 AM, Registered Nurse Unit Manager #9 stated that residents could not reheat food independently and it had to be done by staff in the core microwave to prevent a burn or incident. There were staff who used the breakroom microwave to heat resident food because it was closer, but they should not. Staff were to heat resident food in 20-30 second intervals to ensure it was not too hot. Resident #419 had an incident where they were burned by food being removed from the microwave. During a follow up interview on 4/17/2025 at 1:47 PM, they stated they were unaware Resident #419 was using the breakroom microwave prior to the incident but the resident liked to do things their way. They would have care planned the resident attempting to use the breakroom microwave themselves if they had known. During a phone interview on 4/10/2025 at 1:39 PM, Certified Nurse Aide #162 stated microwaves were in the core and in the breakroom on the unit. They stated residents were not supposed to use the microwave in the breakroom and if they saw a resident in there, they tell the resident they can't be there. They stated on 3/15/2025 they walked into the breakroom and saw Resident #419 in there. The resident told them they had burnt themselves by taking their food out of the microwave. They stated the nurse was right there when the interaction occurred. They stated they weren't sure if the resident always used the microwave in the breakroom but did know the resident liked to do what they wanted. During an interview on 4/10/2025 at 2:14 PM, the Director of Nursing stated the staff were aware of the protocol for reheating food for the residents. They were unaware of any residents in the facility who could access microwaves independently. Residents should not be utilizing the breakroom microwaves but if staff did heat up a resident's food in the breakroom, they would have heat to it in increments and take the temperature prior to giving it to the resident. 10NYCRR 415.12 (h) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49448 51469

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	04/18/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. 46276 Based on observations, record review, and interviews during the recertification survey conducted 4/6/2025-4/18/2025, the facility did not ensure residents maintained acceptable parameters of nutritional status for two (2) of two (2) Residents (Residents #306 and #740) reviewed. Specifically, Resident #306 had significant weight loss and did not receive fortified cran-apple juice, Magic Cups (fortified frozen dessert) and double portioned entrees as planned; and Resident #740 had significant weight loss and planned preferred food items for weight maintenance were missing from their meal trays. Additionally, Resident #306 was not assisted with eating in a dignified manner. The facility policy Comprehensive Nutritional Assessment, revised 9/2023 documented the Registered Dietitian or designee helped identify nutritional risk factors and recommended nutritional interventions based on the individual's medical condition, needs, desires, and goals. The facility policy Fine Dining, revised 3/2025 documented certified nurse aides would serve residents their food per their meal ticket and ensure proper accuracy. Nursing staff would be assigned to deliver and monitor the residents with room trays. The undated facility Oral Nutrition Supplement Substitution List documented fortified juice should be substituted with Ensure Clear if not available; if no Health Shakes, substitute with Ensure Plus and if there were no Magic Cups call the Registered Dietitian. 1) Resident #306 had diagnoses including dementia and failure to thrive (a decline in overall health and function). The 3/18/2025 Minimum Data Set assessment documented the resident had severely impaired cognition, required substantial/maximum assistance of 1 with eating, was 59 inches tall, weighed 71 pounds, and had an unplanned 5% weight loss. The Comprehensive Care Plan initiated 9/2024 documented a potential alteration in nutrition related to adult failure to thrive, dysphagia (difficulty swallowing), dementia, gastro-esophageal reflux disease, and low body mass index (estimates body fat). Interventions were regular diet, ground solids, fortified foods, double portions on meal plan, Ensure (liquid nutritional supplement), and pour liquids into cup before giving to resident. The 12/27/2024 Registered Dietitian #75 nutritional assessment documented the resident weight 75 pounds and triggered for significant weight loss of 6.5% in 30 days, 18.5% loss in 90 days, and 18.7% loss in 180 days. Meal pattern adjustments made were entree x2, fortified juice, super cereal (fortified cereal), yogurt for breakfast, Health Shake, fortified juice, whole milk for lunch, and entree x2, fortified juice, Health Shake, whole milk, and super pudding (fortified pudding) for dinner. Snacks were to be provided on the unit (did not indicate what the snacks were). The 12/2024 Physician #49 progress note documented per nutrition assessment, Resident #306 met the criteria for severe protein-calorie malnutrition due to severe muscle wasting and fat loss. The resident triggered for significant weight loss at 30, 90 and 180 days. Interventions were Health shakes, Magic Cups, and fortified foods. Resident #306's weights documented: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	- on 10/18/2024 82.2 pounds. - on 11/6/2024 80.2 pounds. - on 12/11/2024 75 pounds. - on 1/2/2025 74 pounds. - on 2/10/2025 72.5 pounds. - on 3/5/2025 71 pounds (5.3% weight loss in 3 months). There were no weights documented from 4/1/2025-4/9/2025. The 3/17/2025 physician order documented monthly weights on the 1st and 5th and as needed. The 3/24/2025 physician order documented mirtazapine (an antidepressant used as an appetite stimulant) 15 milligrams by mouth every day between 5:00 PM and 10:00 PM. The 4/2025 resident care instructions documented encourage or assist resident to sit upright after meals, pour Ensure or other fluids into cup prior to giving to the resident, regular diet, ground consistency, thin fluids, encourage the resident to be out of bed for all meals, and the resident was to be in a regular chair with supervision at all times. The 3/18/2025 untimed resident nutritional assessment by Registered Dietician #75 documented the resident weighed 71 pounds and triggered for significant weight loss of 2.1% in 30 days, 5.3% in 90 days and 22.8% in 180 days with an underweight body mass index of 14.4. Registered Dietician #75 documented meal plan adjustments were entree x 2, fortified juice, whole milk at breakfast, entree x2, gravy on side, fortified juice, health shake and whole milk at lunch, entree x2, gravy on side, health shake, super pudding and whole milk at dinner. The 4/8/2025 Dietetic Technician #73 progress note documented a meeting was held with the resident's family representative and sweets were requested for the resident for assistance with appetite. Magic cups were added to their meal tray, fortified foods would be continued, and nutrition would continue to monitor. During an observation on 4/8/2025 at 1:50 PM the resident was served their lunch tray. The meal ticket documented beef and rice stuffed pepper, 8 ounces whole milk, (1) container of fortified cran-apple juice, (1) container of strawberry Health Shake, 4 ounces ground green beans, 2 ounces gravy on side, 4 ounces pureed fruit mix, and (1) vanilla Magic Cup. The meal ticket did not document double portion entree. The strawberry Health Shake, fortified juice, and side of gravy were missing from the tray. The resident consumed 0-25% of their stuffed pepper and green beans, 100% of fruit and 0-25% of their milk. No alternative food items were offered or obtained. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an observation on 4/9/2025 at 1:01 PM, the resident was served their lunch tray. The meal ticket documented 3 ounces ground zesty chicken, 2 ounces poultry gravy, gravy on side, 4 ounces mashed potatoes with gravy, 4 ounces ground broccoli, pureed pineapple tidbits, a vanilla Magic Cup, (1) container of fortified cran-apple juice, and 8 ounces whole milk. The meal ticket did not document double portion entree. The gravy on the side, fortified cran-apple juice, and broccoli were missing from the tray. There was a 4-ounce container of regular apple juice on the tray. The resident's meal tickets from 4/6/2025-4/10/2025 did not list double portions for the resident's entrees. During an observation and interview on 4/9/2025 at 1:04 PM, Certified Nurse Aide #71 stated they checked meal tickets for accuracy as they were assigned to be a meal captain. Meal captains checked resident's tickets for accuracy and if food items were missing, they were required to notify dietary aides who would call the kitchen. They stated regular apple juice was not the same as fortified cran-apple juice, they had never seen the resident get fortified cran-apple juice on their tray and did not know why they were not receiving it. Residents should receive all the items on their meal ticket. At 1:12 PM, Certified Nurse Aide #71 was assisting the resident with eating in a hurried manner and standing over them. Certified Nurse Aide #71 stated they would normally pull up a chair and sit next to the resident and standing over them was not dignified. During an interview on 4/10/2025 at 11:37 AM Licensed Practical Nurse Unit Manager #72 stated Resident #306 had had weight loss. They did not know why they did not receive their fortified juice. They notified Dietetic Technician #73 and did not hear back from them. Licensed Practical Nurse Unit Manager #72 stated they assigned two certified nurse aides every day to be meal captains who responsible to check trays for accuracy. It was important for residents with significant weight loss to receive their food or they could lose more weight. They stated Resident #306 had orders for fortified foods and should have received them. They expected staff to pull up a chair and sit next to a resident when assisting with eating. During an interview on 4/10/2025 at 11:58 AM Dietetic Technician #73 stated they performed nutritional assessments quarterly, annually and with any significant change. Supplements were ordered by them and placed in a meal tracker so the kitchen staff would see and could print the meal tickets. Certified nurse aides and dietary aides were responsible for checking tickets for accuracy. Resident #306 had significant weight loss, and if fortified juices were not available, they should be substituted with Ensure clear. Weekly and sometimes monthly audits were conducted by them. They were not aware Resident #306 was not receiving their fortified foods. 2) Resident #740 had diagnoses including Alzheimer's disease, transient ischemic accidents (mini strokes), nausea and weakness. The 4/2/2025 Minimum Data Set assessment documented the resident was cognitively intact, required set up assistance with eating, had no swallowing disorders, and had a 5% weight loss not prescribed by a physician. The Comprehensive Care Plan initiated 4/3/2025 documented potential alteration in nutrition related to Alzheimer's Disease, gastro-esophageal reflux disease, and chronic obstructive pulmonary disease (lung disease). Interventions included regular diet, regular textures, thin liquids, extra 240 milliliters fluids, intake >75%, identify/honor food preferences. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The 4/2025 resident care instructions documented the resident had their own upper and lower teeth, required set up/clean up assistance for meals and to open containers, cut up meat and butter bread. The Unit 3 South weight book documented the following: for Resident #306: - 10/22/2024, 266.2 pounds. - 11/14/2024 242 pounds. - 1/17/2025 227.4 pounds. - 2/26/2025 216 pounds. - 3/27/2025 211.7pounds. - 4/4/2025 203 pounds (23.7% weight loss in 6 months) The 1/17/2025 Registered Dietitian #75 progress note documented the resident triggered for significant weight loss of 2.4 % in 30 days and 14.2 % in 90 days. Meal plan adjustments were apple juice x 2 and hot oatmeal at breakfast; cheese and crackers, chicken noodle soup x 2, chocolate milk, and mashed potatoes with gravy for lunch and dinner. The 1/22/2025 Physician #49 progress note documented the resident had monthly weights their weight was trending down, and they received a regular diet. The 2/26/2025 Registered Dietitian #75 progress note documented the resident's weight was 227.4 pounds and they had a significant weight loss at 30, 90 and 180 days related to inadequate by mouth intake. The meal plan was adjusted per the resident's preferences. Resident was to receive chocolate milk and mashed potatoes at lunch and dinner to provide extra calories/protein. Snacks provided and staff to encourage intake of food/fluids. Medical was aware. The 4/8/2025 Registered Dietitian #75 progress note documented the Resident triggered for significant weight loss at 30, 90, and 180 days, medical was notified to discuss an appetite stimulant due to interventions not working and food preferences continued to be updated. Resident received nutritional supplements on their meal tray and the Resident continued to lose weight despite their interventions. There was no documented evidence of a physician order for an appetite stimulant. During an observation on 4/6/2025 at 1:54 PM, the resident's lunch meal ticket listed 1 can cola, 4 ounces turkey, 4 ounces gravy, apple juice, 6 ounces tomato soup with unsalted crackers, 4 ounces mashed potatoes, peanut butter and jelly sandwich, 4 ounces of glazed carrots, 4 ounces tropical fruit, strawberry yogurt, and a chocolate Magic Cup. The Magic Cup, fruit cup, peanut butter and jelly sandwich, and strawberry yogurt were missing from the resident's tray. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an observation on 4/7/2025 at 10:02 AM, the resident's breakfast meal ticket documented 8 ounces milk, cranberry juice, 2 slices of French toast, 2 ounces breakfast sausage, two strawberry yogurts, margarine, and syrup. One slice of French toast and the cranberry juice were missing from the tray. During an observation on 4/9/2025 at 1:14 PM, the resident received their lunch tray and was not assisted with set up. Their meal ticket documented cola, apple juice, 6 ounces tomato soup and crackers, 3 ounces zesty chicken, 2 ounces poultry gravy, peanut butter and jelly sandwich, 1/2 cup parslied potatoes, 4 ounces mashed potatoes, 4 ounces peas, 4 ounces pineapple tidbits, one package of cheese and crackers, two strawberry yogurts, and a chocolate Magic Cup. The tomato soup and crackers and strawberry yogurts were missing from their tray. During an interview on 4/15/2024 at 9:54 AM Resident #740 stated they lost a lot of weight due to the food not tasting good. They stated Dietetic Technician #73 visited them all the time to ask about food preferences, but the food never showed up on their trays. They stated they had never been seen by the physician regarding their weight loss. During an interview on 4/10/2025 at 11:58 PM Dietetic Technician #73 stated Resident #740 had significant weight loss, could make their own decisions, and food preferences were often discussed with the resident. Resident #740 preferred yogurts and peanut butter and jelly pocket sandwiches so they added them up to the resident's meal trays. They stated if tomato soup, crackers and yogurt were on the resident's meal ticket they should receive them. If the resident did not receive preferred foods, it was not acceptable and could lead to further weight loss. During an interview on 4/15/2025 at 9:58 AM Certified Nurse Aide #74 stated they had never seen Magic Cups or supplements on Resident #740's meal trays. They were unsure if the resident had lost weight. During an interview on 4/15/2025 at 12:47 PM Registered Dietitian #75 stated residents had a full annual nutritional assessment and if they exhibited changes, such as significant weight loss, the registered dietitian should re-assess. Food preferences and supplements were initiated first, then the resident would be re-assessed and medical notified if the interventions did not work. Resident #306 had significant weight loss, received supplements such as fortified juice and if the juice was not available, it should be replaced by Ensure clear. The Director of Dietary notified the registered dietitians if a supplement was not available. There was a substitution list in the kitchen if a supplement was not available. Resident #306 should have received their supplements on their meal tray to prevent further weight loss. Registered Dietitian #75 stated Resident #740 had significant weight loss and multiple food preferences were honored. It was unacceptable for the resident not to receive their soup and yogurts; those were the resident's choices and assisted in maintaining their weight. Dietary staff and certified nurse aides should check meal trays for accuracy and notify them if an item was not available. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 4/15/2025 at 11:15 AM the Director of Dietary Services stated dietary staff gathered the cold food items, and a cart was brought to the unit. The cold food cart included milks, juices, fortified juices and Health Shake supplements to be distributed to the residents per their meal ticket. Dietary aides and certified nurse aides were responsible for meal ticket accuracy. If a resident required a supplement and it was not available, a substitution list would tell them what to put on the tray. The facility did not have fortified cran-apple juice due to a national recall. Staff should substitute fortified cran-apple with fortified orange juice or Ensure Plus. If a resident had supplements ordered they should receive them to maintain their nutritional needs. During an interview on 4/15/2025 at 1:30 PM Nurse Practitioner #23 stated Resident #740 had significant weight loss. They stated the resident should receive Ensure and fortified foods on their meal trays. If preferred food items were missing from their tray, it was not acceptable. Resident #740 had preferred food items such as soup and yogurt to assist them in maintaining their weight and nutritional needs. It was important for the resident to receive them to prevent further weight loss. 10NYCRR 415.12(i)1

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	04/18/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48446 Based on observations, record review, and interviews during the recertification survey conducted [DATE]-[DATE], the facility did not ensure that pain management was provided to residents who required such services consistent with professional standards of practice for one (1) of one (1) resident (Residents #179) reviewed. Specifically, Resident #179 did not have their prescribed pain patch placed as ordered and the pain patch was signed as administered. Findings include: The facility policy Pain Management Program, effective [DATE] documented pain would be managed and assessed to promote optimal functioning and maintain quality of life. The facility Medication Administration Policy and Procedure, revised ,d+[DATE], documented the nurse administering medication was responsible to administer the right medication to the right resident in the right dose at the right time, using the right method of administration and the right method of documentation. Resident #179 had diagnoses including pain, morbid obesity, and hemiplegia (weakness on one side of their body). The [DATE] Minimum Data Set assessment documented the resident had intact cognition, required partial/moderate assistance of 1 for most activities of daily living, received a scheduled pain medication regimen, received as needed pain medications, and did not reject care. The Comprehensive Care Plan initiated [DATE] and revised [DATE] documented Resident #179 had pain. Interventions included repositioning, administration of medication as ordered, and documenting response to pain medication. The [DATE] Nurse Practitioner #23 order documented Lidocaine patch 4% one patch topically to left knee every day (between 8:00 AM and 1:00 PM) for pain. The ,d+[DATE] Medication Administration Record documented Lidocaine patch 4% one patch topically to left knee every day (between 8:00 AM and 1:00 PM) for pain: - time expired for administration on ,d+[DATE] and ,d+[DATE] - was not administered on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and ,d+[DATE] The following observations of and interviews with Resident #179 were made: - on [DATE] at 11:08 AM, Resident #179 reported they had chronic pain, especially in their leg, that interfered with their ability to leave their room and go to the first floor. They had an order for a Lidocaine patch but most days it was not administered, and they were not sure why. There was no Lidocaine patch applied on the resident. They self-propelled themselves to the hallway and asked Licensed Practical Nurse #50 to administer the Lidocaine patch and Licensed Practical Nurse #50 stated the patch was not in the medication cart and they would order it from pharmacy. The resident had facial grimacing when they asked for the pain patch and their voice was raised. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on [DATE] at 8:32 AM, in their wheelchair in their room without a Lidocaine patch on their leg. They reported their pain level as 6 out of 10 and stated they were unable to move their leg secondary to throbbing pain. They stated they had been without the patch for one month and asked every nurse for it and it was not administered. Most nurses offered an Icy Hot patch but that did not alleviate their pain, only the Lidocaine patch worked. - on [DATE] at 8:44 AM, in bed and stated they were not able to get out of bed because their knee was throbbing. They did not receive their patch yesterday and wanted it. A Lidocaine patch was not observed on their leg. They reported a current pain level of ,d+[DATE] out of 10 and throbbing in their knee. At 10:16 AM, in their room in their wheelchair without a Lidocaine pain patch on their leg. - on [DATE] at 9:07 AM, in their room sitting in their wheelchair without a Lidocaine pain patch on their leg. They reported their pain level as 5 out of 10 and wanted the Lidocaine pain patch as it was the only thing that alleviated their pain. At 11:15 AM, the resident was smiling and had a Lidoderm patch on their right knee. They reported improved pain level of 3 out of 10 with the pain patch and stated the pain patched helped and wished it was administered every day as ordered. During an interview on [DATE] at 11:19 AM, Certified Nurse Aide #51 stated when a resident complained of pain, they told the nurse and often the residents told them the nurse did not do anything about it. Resident #179 was on their assignment and was not wearing a pain patch. During an interview on [DATE] at 11:48 AM, Licensed Practical Nurse #52 stated Resident #179 had an order for a Lidocaine patch every day and it was not administered as ordered because the patch was kept in the treatment cart and not the medication cart. They meant to go to the treatment cart to get the patch but forgot, therefore the resident never received the medication that was signed as administered. Licensed Practical Nurse #52 stated they should not sign off on medications before they were administered as they might forget to go back and administer that medication. If a resident did not receive their ordered pain medication their pain might not be controlled. During an interview and observation on [DATE] at 5:33 PM, Resident #179 was on the first floor self-propelling in their wheelchair. They had facial grimacing and there was no Lidocaine patch on their knee. They stated their pain level was 7 out of 10 and they wished the pain patch had been administered in the morning because they wanted it, and their knee was throbbing. During an interview and observation on [DATE] at 3:49 PM, Resident #179 was on the first floor common area without a Lidocaine patch on their leg and reported their pain level was a 4 out of 10. They stated they were not offered their Lidoderm pain patch only an Icy Hot patch which did not work. During an interview on [DATE] at 8:59 AM, Licensed Practical Nurse #70 stated it was important to administer pain medication as ordered so residents mobility was not restricted, and they were not in pain. They did not apply the Lidocaine patch to Resident #179 on [DATE] as the resident was getting care from the certified nurse aide at the time and they were going to go back and they forgot. They were unaware the Lidocaine patches were kept in the treatment cart and believed they were kept in the medication cart. They signed the patch as administered and should not have signed for the patch until after it had been administered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:12 PM, Licensed Practical Nurse Unit Manager #40 stated if a resident had an order for a Lidocaine Patch to be given daily, they expected it to be administered. If it was not administered the resident could be in pain. Staff should never sign a medication was administered until it was administered to ensure the resident received their medications and did not refuse them. They believed the Lidocaine patches were in the medication cart. They were a floor stock item and ordered from central supply with additional patches in the medication room. During an interview on [DATE] at 1:44 PM, the Director of Nursing stated pain medication should be administered as ordered. Nurses should not sign off medication until it was administered. If pain medication was not administered as ordered the resident could be in pain. 10NYCRR 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	04/18/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 49448 Based on observations, record review, and interviews during the recertification survey conducted 4/6/2025-4/18/2025, the facility did not provide on-going assessment and monitoring of bed rails (side rails) for one (1) of one (1) resident (Resident #41) reviewed. Specifically, Resident #41 had bed rails on both sides of the bed and did not have an order for bed rails, a comprehensive care plan that included the use of bed rails, regular maintenance inspections for entrapment, or regular assessments to ensure the bed rails remained appropriate. Findings include: There was no documented evidence of a facility policy for the use of bedrails. Resident #41 had diagnoses including quadriplegia (weakness or paralysis of arms and legs), reduced mobility, and need for assistance with personal care. The 2/27/2025 Minimum Data Set assessment documented the resident was cognitively intact, was dependent for all activities of daily living, and did not reject care. The Comprehensive Care Plan, initiated 1/29/2024 and revised 12/8/2024, documented the resident was dependent for activities of daily living/ mobility. Interventions included the resident was dependent on 2 for bed mobility. The comprehensive care plan did not include the use of bed rails. The 2/10/2023 Side Rail Consent form documented alternatives attempted were previous physical and occupational therapy services and other mobility aide (did not specify what the mobility aide was). There was no documented evidence risks/ benefits of bedrails were discussed, alternatives attempted, or continued consent was obtained beyond this date. There was no documented physician order for the use of bed rails. Two quarter rails were discontinued on 8/12/2024 by system discharge. Quarterly side rail safety risk assessments were documented as completed by Assistant Director of Nursing #47 on 1/29/2024, 4/19/2024, and 3/20/2025. All three assessments documented the resident demonstrated poor bed mobility or difficulty moving to a seated position on the side of the bed. Bed entrapment zone inspections were documented as completed by the Director of Maintenance in April 2024 and in January 2025. Therapy progress notes documented: - on 3/15/2024 by Occupational Therapist #163 the resident had some generalized movement in left shoulder/ elbow without significant functional use. - on 8/17/2024 by Physical Therapist #164 the resident required total assistance at baseline for bed mobility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 9/9/2024 by Physical Therapist #42 the resident required total assistance of two for bed mobility. - on 12/19/2024 and 2/20/2025 quarterly interdisciplinary rehabilitation screens by Occupational Therapist #165 documented no changes in self-care abilities. There was no documented evidence of bed rail use or assessments that determined appropriate use. During an observation and interview on 4/10/2025 at 11:31 AM, Resident #41 was sitting up in bed, and had bilateral bed rails on their bed. They stated they only got out of bed for appointments and used the bed rails to hold onto during wound care. They had the bedrails for as long as they had been in the facility and wanted the bed rails. During an interview on 4/15/2025 at 10:41 AM, Certified Nurse Aide #166 stated Resident #41 had enabler bars they used to hold themself during wound dressing changes or during bed linen changes. The residents were not supposed to have them, and the facility had tried to take them off, but the resident refused. During an interview on 4/15/2025 at 10:54 AM, Licensed Practical Nurse Assistant Unit Manger #149 stated Resident #41 was allowed the bed rails because they were grandfathered in. Therapy often asked if the resident still used them. One of the bars needed to be removed every time the resident went on an appointment and maintenance had to put it back on after they came back, but they were not sure if maintenance checked the other rail. They were not sure if there were any routine assessments that needed to be completed. During an interview on 4/16/2025 at 11:58 AM, the Director of Rehabilitation stated bed rails needed to be appropriate for the resident and used to improve independence. There was a quarterly therapy screen and nursing also had to complete a quarterly assessment. Resident #41's bed rails were taken off yesterday as they were not appropriate for bed rails. They had required total assistance for a long time and did not have any strength in their hands. There was risk of the resident getting their hands stuck in the bed rails, bruising, or entrapment. They stated they attempted to remove the resident's bed rails in the past, but the resident repeatedly refused. The quarterly therapy screens were not completed as required and the ones completed did not mention the use of bed rails. During an interview on 4/16/2025 at 12:44 PM, the Director of Maintenance stated maintenance checks were completed on bed rails once a year and entrapment zones were tested . If nursing reported the bedrails were loose, they were tightened. It was important for routine assessments to ensure safety and prevention of bed entrapment. The bed rail inspections were due this month. During an interview on 4/17/2025 at 10:59 AM, the Assistant Director of Nursing #47 stated the facility policy was there were no side rails. Resident #41 adamantly wanted to keep their bilateral quarter bed rails. It required a physician order, and they were not sure why Resident #41 did not have an order for them. The resident had an order discontinued by the system on 8/12/2024 for a hospitalization and it was never reordered upon their return. They stated they were responsible to ensure quarterly assessments were completed and they just did not get done. There was one done in March but otherwise the last one was a year ago. It was important the assessments were completed for safety risk. They were not sure if reeducation of risks/ benefits or consents needed to be obtained routinely or just once prior to installation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10NYCRR 415.12(h)(1)(2)

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	04/18/2025

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 48052 Based on record review and interviews during the recertification survey conducted 4/6/2025-4/18/2025, the facility did not ensure a resident's total program of care, including medications and treatments, was reviewed by the medical provider for one (1) of one (1) resident (Resident #322) reviewed. Specifically, Resident #322 was readmitted to the facility from the hospital with sliding scale insulin (the amount of insulin administered was based on the blood glucose readings) instructions that were not initiated, the resident's finger sticks (blood glucose readings) were not consistently done as ordered and there was no evidence the provider was aware. Subsequently, the resident was readmitted to the hospital with hyperglycemia (above normal blood glucose levels). Findings include: There were no documented facility policies on Admission/Readmission medical orders. Resident #322 had diagnoses including diabetes and end stage kidney disease. The 10/9/2024 Minimum Data Set assessment documented the resident had intact cognition, required partial to moderate assistance with most activities of daily living, and received insulin injections every day during the last 7 seven days. The hospital discharge summary documented the resident was hospitalized from 12/10/2024-3/5/2025 with a primary diagnosis of uremia (buildup of waste products in the blood). The Endocrine department was consulted for management of hyperglycemia and insulin recommendations. Discharge medications included Insulin Lispro (short-acting insulin) inject as directed per algorithm (used to titrate insulin to maintain adequate blood glucose levels), not to exceed 110 units; Tresiba (long-acting insulin) Flex Touch pen, inject 45 units into skin nightly. The insulin sliding scale instructions documented directions for insulin coverage for blood glucose levels without a bolus tube feeding and with bolus tube feeding (glucose checked 30 minutes or less prior to administering tube feeding). The 3/5/2025 Registered Nurse #145, documented the admission orders were reviewed with Nurse Practitioner #78, discontinue insulin lispro and monitor fingerstick four times a day. The 3/6/2025 facility admission orders signed by Nurse Practitioner #32 documented Tresiba 47 units subcutaneously at bedtime; finger sticks (blood glucose monitoring) every day at 8:00 AM, 2:00 PM, 5:00 PM and 8:00 PM, call physician if below 60 milligrams/deciliter or over 400 milligrams/deciliter. There was no documented evidence of a physician order for sliding scale insulin coverage to accompany the blood glucose monitoring. The 3/7/2025 Nurse Practitioner #78 readmission progress note documented a medication review/reconciliation and included Tresiba 47 units daily at bedtime. The review did not include sliding scale short-acting insulin. The resident had diabetes, and the plan was to monitor the resident's Hemoglobin A1C (measures long term average blood glucose levels), monitor for hypoglycemia (low blood glucose levels) and hyperglycemia, low carbohydrate diet, avoid concentrated sweets (resident was on a tube feeding for nutritional support), and continue Tresiba. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/10/2025 Physician #49 Initial History and Physical documented the resident was seen for readmission after hospitalization . Blood sugars were often greater than 200 milligrams/deciliter. The plan was to increase the Tresiba from 45 units to 47 units given frequent hyperglycemia. There was no documentation regarding hospital discharge recommendations for sliding scale insulin coverage. The 3/2025 Medication Administration Record documented Nepro/Carb Steady Oral Liquid (tube feeding formula) bolus via gravity 250 ml at 8:00 AM, 2:00 PM, 5:00 PM, 8:00 PM, and 11:00 PM; finger sticks every day at 8:00 AM, 2:00 PM, 5:00 PM, and 8:00 PM, call physician if below 60 milligrams/deciliter or over 400 milligrams/deciliter. Finger sticks were documented as not done on 3/7/2025 at 2:00 PM, 3/8/2025 at 2:00 PM, 3/11/2015 at 8:00 PM, 3/11/2025 at 2:00 PM, 3/13/2025 at 8:00 AM and 2:00 PM, 3/14/2025 at 8:00 PM, 3/15/2025 at 2:00 PM and 8:00 PM, 3/18/2025 2:00 PM, 3/20/2025 at 2:00 PM and 5:00 PM, 3/22/2025 at 2:00 PM, 3/24/2025 2:00 PM, 3/25/2025 at 2:00 PM, 3/26/2025 8:00 PM, 3/27/2025 2:00 PM, 3/29/2025 2:00 PM, and 3/30/2025 2:00 PM and 8:00 PM. The resident's fingerstick readings results were as follows: - from 3/5/2025-3/16/2025 ranged from 140-389 milligrams/deciliter. - from 3/17/2025-3/31/2025 ranged from 112-491 milligrams/deciliter. The 4/2025 Medication Administration Record (MAR) documented finger sticks every day at 8:00 AM, 2:00 PM, 5:00 PM, and 8:00 PM, call physician if below 60 milligrams/deciliter or over 400 milligrams/deciliter. Finger sticks were documented as not done on 4/1/2025 at 8:00 AM and 2:00 PM, 4/2/2025 at 8:00 PM, 4/3/2025 at 2:00 PM, 4/5/2025 at 2:00 PM, and 4/8/2025 at 2:00 PM. The resident's fingerstick readings results from 4/1/2025-4/8/2025 ranged 140-400 milligrams/deciliter. The 4/8/2025 Physician #49 progress note documented the resident had diabetes and was on Tresiba. The resident's most recent glycemic status (hemoglobin A1C or glucose management indicator0 was not known or had not been performed. There was no documented evidence the physician was aware of the resident's high blood glucose readings or that finger sticks were not completed as ordered. The 4/9/2025 Registered Nurse #133 progress noted documented the resident was increasingly lethargic today, and their blood sugar reading was high on the glucometer. Nurse Practitioner #78 notified and in route to bedside. 10 unit of Lispro Insulin order and administered. Emergency Medical Services called, and the resident was sent to the hospital. The 4/9/2025 Nurse Practitioner #78 progress note documented they were notified by nursing the resident's fingerstick was greater than 500 milligrams/deciliter and had a temperature of 101.3 degrees. The resident was clammy, and difficult to arouse. The Medical Director was notified, 911 was called, and the resident was sent to the Emergency Department. There was no documented evidence Nurse Practitioner #78 was aware of the resident's high blood glucose readings or that finger sticks were not completed as ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/15/025 at 3:23 PM, Nurse Practitioner #78 stated if a resident had a lengthy hospital stay, they would come back and continue to be under their service. They stated they did not discontinue any orders from the hospital. They usually reviewed the discharge paperwork and saw the resident within 24- 48 hours of readmission. They stated the Endocrine clinic managed the resident for their diabetes and they would not change any of the endocrine orders. They were not sure about the hospital discharge orders with the fingerstick and sliding scale. They stated the results of the resident's blood sugars would determine if they needed a sliding scale. They saw the resident multiple times and was not notified by nursing of blood sugar issues. The resident should have been on a sliding insulin scale per the hospital Endocrinologist discharge orders. The sliding scale was missed by the admitting nurse who called and reviewed the orders with the provider team. If a resident did not get the insulin ordered by Endocrine, they could end up hyperglycemic. During an interview on 4/16/2025 at 12:05 PM, Registered Nurse #145 stated they reviewed the medications for newly admitted residents. They received a discharge summary and discharge medication summary and reviewed the orders with the admitting nurse practitioner or the provider. Resident #322 was a longevity resident, and they would have reviewed the order with longevity Nurse Practitioner#78. The resident had a new tube feeding order with standard sliding scale insulin coverage per their discharge orders. They stated they discontinued the insulin because the resident had a lot of nausea and vomiting, and the nurse practitioner decided to just do fingerstick and see how the resident did with the long action insulin. The discharge orders had an injection algorithm, and two scales, one for a tube feeding and one without. Those were discontinued, and the nurse practitioner ordered to monitor the fingerstick. When the resident was admitted the blood sugar checks were at the same time as the bolus tube feeding. The fingerstick were not getting checked during the tube feeding time. Blood sugars should be checked prior to the bolus feeding to verify accurate sugar levels. During an interview on 4/18/2025 at 1:37 PM, the Director of Nursing stated they oversaw the admission nurses, and all orders should be reviewed for a new admission. When the nurse called the provider, they should go over all orders to finalize. All medications were reviewed by the providers, and it was the providers decision what to order for the resident. 10 NYCRR 415.15(b)(2)(iii)

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	04/18/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. 50561 Based on observations, record review, and interviews during the recertification surveys conducted 4/6/2025-4/18/2025, the facility did not ensure that residents were free of any significant medication errors for one (1) of one (1) resident (Resident #1098) reviewed. Specifically, Resident #1098 was administered lispro insulin (a fast-acting insulin) and was not provided food. Findings include: The facility policy Medication Administration Policy and Procedure, last revised 11/2021, documented when medications were ordered before or after meals, assure the medicine was given correctly in relationship to meals Resident #1098 had diagnoses including diabetes. The 4/1/2025 Minimum Data Set assessment documented the resident had intact cognition, required set up assistance for eating, and received insulin injections daily. The Comprehensive Care Plan, initiated 3/31/2025, documented the resident had diabetes with hyperglycemia. Interventions included monitor for signs and symptoms of high glucose levels and insulin shock. The 4/1/2025 Nurse Practitioner #23's orders documented a glucose check (finger stick) every day at 7:00 AM, 12:00 PM and 5:00 PM; administer lispro insulin based on the following sliding scale: - if glucose level 151-200 milligrams/deciliter give 3 units - if glucose level 201-250 milligrams/deciliter give 6 units - if glucose level 251-300 milligrams/deciliter give 9 units - if glucose level 301-350 milligrams/deciliter give 12 units - if glucose level 351-400 milligrams/deciliter give 16 units The Fingerstick Report documented on 4/7/2025 at 7:00 AM the resident's glucose level was 196 milligrams/deciliter The April 2025 Medication Administration Record documented on 4/7/2025 at 7:00 AM Licensed Practical Nurse #26 administered the resident 3 units of lispro insulin. The 4/7/2025 7 North 7:00 AM-3:00 PM Assignment Sheet documented Resident #1098 had an outside appointment that day at 9:15 AM. The Eating/Fluid Report did not document any breakfast intake for the resident on 4/7/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an observation on 4/7/2025 at 11:30 AM, Resident #1098 was not in their room and their breakfast tray was sitting untouched on their table. During an interview on 4/8/2025 at 10:04 AM, Resident #1098 stated they did not have breakfast before they went to their appointment on 4/7/2025. Their daughter had to get them something from the vending machine while at the medical appointment because they were about to go down from not eating. During an interview on 4/15/2025 at 10:40 AM, Certified Nurse Aide #27 stated if a resident left for an appointment before a meal, their meal tray was left for them so they could eat it when they came back. They saw residents leave for appointments without any food and did not think there were any early breakfasts offered. There was nothing different done for diabetic residents. During an interview on 4/15/2025 at 12:32 PM, Licensed Practical Nurse #26 stated if a resident had to leave early for an appointment, they could get a sandwich or snacks from the kitchenette. Diabetics should get something to eat because their sugar could drop. If a resident received insulin before they left that would be even worse. Resident #1098 was a diabetic and received insulin based on a sliding scale. They did not recall the resident going out on an appointment last week and did not send them with any food, but food should have been sent with the resident just in case. During an interview on 4/16/2025 at 12:21 PM, Registered Nurse Manager #30 stated outside appointments were listed on the daily assignment sheet and they notified the dietetic technician if a resident was going to need a breakfast due to an early appointment. They were not always aware of every appointment and if not, [NAME] Clerk #110 might catch that a resident needed a meal and order one. There was no concrete process in place to ensure meals were provided. Resident #1098 was a diabetic and on sliding scale insulin before meals. The resident had an appointment on 4/7/2025 with a pickup time of 8:15 AM. They did not call the dietetic technician to get the resident food because they were unaware of the appointment. After reviewing the medication administration record, they stated at 7:00AM on 4/7/2025 the resident's glucose level was 196 and they were given 3 units of insulin. If a resident was on a sliding scale the facility needed to make sure they had food to take with them and the certified nurse aide should know the resident needed to eat. Without food the resident could become hypoglycemic and confused. Someone should have touched base to make sure the resident had food. During an interview on 4/16/2025 at 12:59 PM, [NAME] Clerk #110 stated if a resident had an early appointment, they or the certified nurse aide tried to get the resident an early breakfast or something to bring with them from the unit refrigerator. It was important to make sure that a resident did not go hungry. Resident #1098 had an appointment on 4/7/2025 and was picked up around 8:15 AM. An aide went with them and their family met them at the office. They did not call for any food for the resident to take with them. During an interview on 4/16/2025 at 1:06 PM, Certified Nurse Aide #109 stated only residents that went to dialysis received food to take with them not residents who went on regular appointments. On 4/7/2025 at 8:15 AM they went on an appointment with Resident #1098 and did not bring a meal for the resident. While at the appointment the resident told them they were hungry and had not yet eaten. The resident's daughter, who met them at the appointment, had to get the resident something to eat. 10NYCRR 415.12(m)(2)

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	04/18/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48895 Based on observations, record review, and interviews during the recertification and abbreviated (NY00358079) survey conducted 4/6/2025-4/18/2025, the facility did not ensure drugs and biologicals were stored in accordance with currently accepted professional standards for five (5) of five (5) resident floors (3rd, 4th, 5th, 6th, and 7th floors). Specifically, the 4th, 5th, 6th, and 7th floors had unattended and unlocked treatment/medication carts; the 3rd, 4th, and 7th floors had medication refrigerators without daily temperature monitoring; the 3rd, 5th, and 6th floors had medications without open dates; and the 4th and 7th floors medication rooms had an excessive number of discontinued medications. Findings include: The facility policy Storage of Medications, dated 8/2020, documented all medications dispensed by the pharmacy were stored in the pharmacy container with the pharmacy label. When the original seal of a manufacturer's container or vial was initially broken, the container or vial would be dated. If a vial or container was found without a stated date opened, the date opened will automatically default to the date dispensed and the expiration date would be calculated accordingly. All medications were maintained with the temperature ranges for refrigerated medications at 36 to 46 degrees Fahrenheit with a thermometer to allow temperature monitoring. The facility should maintain a temperature log in the storage area to record temperatures at least once a day. Medication rooms, carts, and medication supplies were locked when they were not attended by persons with authorized access. The undated facility document, Treatment Cart Supply List, documented the following items were located in the treatment carts, wound cleaner, normal saline, gauze, Kling wrap (type of gauze), abdominal gauze pads, 3 types of wound dressings, compression wraps, band aids, bacitracin (antibiotic ointment), barrier cream, z-guard (zinc oxide ointment), and anti-fungal powder. Unsecured Medication and Treatment Carts The following observations of unsecured medication and treatment carts were made: - on 4/6/2025 at 10:42 AM, the 4th floor C side treatment cart located to the left of the nurse's station was unlocked. Items inside the cart included 2 prescription creams for Resident #160, 1 prescription ointment for a discharged resident, 1 unlabeled anti-fungal cream, methyl muscle ointment, silicone cream, gauze, internal urinary catheter insertion trays, a wound care dressing, and betadine/iodine swabs. No staff were visible in the vicinity of the cart. - on 4/6/2025 at 12:53 PM, the 4th floor South side treatment cart located across from the nurse's station was unlocked. Items inside the cart included oxygen tubing, band aids, thermometer, thermometer covers, enemas, skin protectant wipes, sterile water, anti-embolism hose, bacitracin, syringes, lubricating jelly, iodine swabs, internal urinary catheter insertion tray, wound care dressings, gauze, gloves, and blood pressure cuff. There were 2 residents in the area and no staff in the vicinity of the cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- on 4/6/2025 at 1:13 PM, the 4th floor C side treatment cart located to the left of the nurse's station was unlocked. No staff were visible in the vicinity of the cart. - on 4/6/2025 at 4:45 PM, the 6th floor C side treatment cart was unlocked. Items inside the cart included a glucometer, alcohol wipes, medical tape, insulin syringes, gauze, protective barrier wipes, silicone dressing, lancets for glucometer, four wander alert bracelets, blood specimen tubes, iodine swabs, wound wash, gloves, hand sanitizer, and a container of bleach wipes. No staff were visible in the vicinity of the cart. - on 4/7/2025 at 6:18 AM, the 7th floor treatment cart located outside room [ROOM NUMBER] was unlocked. Items inside the cart included ostomy supplies, several ointments, antifungal cream, and lancets for blood sugar checks. There was a resident in a chair in the common room, and the cart was at the wall that meets the common area. No staff were visible in the vicinity of the cart. - on 4/7/2025 at 6:21 AM, the 4th floor B side medication cart was unlocked. - on 4/7/2025 at 8:10 AM, the 4th floor C side treatment cart located to the left of the nurse's station was unlocked. No staff were visible in the vicinity of the cart. - on 4/7/2025 at 8:54 AM, the 4th floor C side treatment cart located outside room [ROOM NUMBER] was unlocked. The licensed practical nurse was around the corner behind the nurse's station. - on 4/7/2025 at 8:57 AM, the 4th floor A side treatment cart located near room [ROOM NUMBER] was unlocked. No staff were visible in the vicinity of the cart. - on 4/7/2025 at 11:06 AM, the 4th floor A side treatment cart located near room [ROOM NUMBER] was unlocked. No staff were visible in the vicinity of the cart. There were 4 residents in that common area, one resident was independently propelling themself in their wheelchair. - on 4/8/2025 at 9:08 PM, the 4th floor A side medication room door was not latched closed. No staff were visible in the vicinity of the cart. - on 4/8/2025 at 9:50 PM, the 6th floor A side treatment cart located near room [ROOM NUMBER] was unlocked. The nurse was passing medications in room [ROOM NUMBER]. - on 4/8/2025 at 10:13 PM, the 5th floor D side treatment cart located near room [ROOM NUMBER] was unlocked. There was no staff was present in the area. There were residents walking in the core area. Items inside the cart included petroleum jelly, albuterol (breathing treatment), anti-bacterial ointment, silicone cream, border gauze, wound dressings, vitamin A&D ointment, hydrocortisone cream, and bacitracin zinc ointment. No staff were visible in the vicinity of the cart. - on 4/8/2025 at 11:32 PM, the 4th floor C side medication cart located between rooms [ROOM NUMBERS] was unlocked. No nursing staff were present in the hallway. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- on 4/8/2025 at 11:33 PM, the 4th floor C side treatment cart located near room [ROOM NUMBER] was unlocked. There was no nursing staff present in the hallway. Items inside the cart included 3 prescription creams for Resident #160, 1 prescription ointment for a discharged resident, methyl muscle ointment, silicone cream, skin protectant wipes, internal urinary catheter insertion trays, wound dressings, and iodine swabs. 2 residents traveled between the 2 unlocked carts at 11:41 PM, 11:42 PM, and 11:45 PM. - on 4/9/2025 at 9:05 AM, the 4th floor North treatment cart to the left of the nurse's station was unlocked. No staff were visible in the vicinity of the cart. - on 4/9/2025 at 10:29 AM, the 7th floor treatment cart was left unlocked and unattended when Wound Care Registered Nurse #128 went into a resident's room for wound care. Items in the cart included silver nitrate sticks, two cell phones, gauze, anti-fungal powder, scissors, and box of #10 scalpels. - on 4/10/2025 at 1:23 PM, the 4th floor D side medication cart was unlocked and unattended with a resident sitting behind the nurse's station. Licensed Practical Nurse #129 was down the hallway, walking towards the medication cart, and stated the medication cart should be always locked so no one could have access to it. They stated they did not lock the cart because when they left the cart Licensed Practical Nurse #130 was training them and should have locked it when they left it unattended. - on 4/12/2025 at 12:20 PM, the 7th floor B side medication cart located in the hall across from room [ROOM NUMBER], was unlocked. - on 4/16/2025 at 12:13 PM, the 6th floor South treatment cart was unlocked. Items inside the cart included saline syringes and dressing supplies. - on 4/17/2025 at 2:10 PM, the 4th floor North treatment cart, located to the left of the nurse's station was unlocked and unattended. There was a resident walking in the hallway. - on 4/18/2025 at 9:49 AM, the 4th floor North treatment cart was unlocked. There was one resident at the nurse's station During an interview on 4/7/2025 at 6:23 AM, Licensed Practical Nurse #14 stated that treatment ointments were kept in the treatment cart. If a resident had a dressing treatment or medication for dressings, it was stored in the treatment cart. During an interview on 4/7/2025 at 6:41 AM, Licensed Practical Nurse #131 stated they were assigned the 4th floor B side medication cart. The medication cart was supposed to be always locked for privacy and to make sure residents did not access medications. The unit had a few residents that wandered. Their assigned medication cart was unlocked because they normally left it unlocked on the night shift as residents were sleeping. They stated they should always lock the cart when unattended. During an interview on 4/9/2025 at 10:42 AM, Wound Care Registered Nurse #128 stated they should lock the treatment cart when it was not attended because anyone could touch it and open it. If someone got in the cart, they could take items. Upon opening the cart and they noted the scalpels and stated those items could cause harm. The silver nitrate sticks were activated when touched to the skin and could be a problem if someone got their hands on them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/16/2025 at 12:12 PM, Licensed Practical Nurse Assistance Unit Manager #40 stated medication carts and treatment carts should be locked when not in use because residents, visitors, and other employees could get into them. There were ointments and creams in the treatment cart that could be harmful if ingested. Medication Refrigerators During an observation and interview on 4/7/2025 at 6:28 AM, the 7th floor medication room refrigerator was not monitored for appropriate temperature on the temperature log sheet attached to the front of the door on 4/2/2025, 4/3/2025, and 4/5/2025. Licensed Practical Nurse #14 stated the nurse on the overnight shift was responsible for monitoring the refrigerator temperatures. During an observation and interview on 4/7/2025 at 6:41 AM, the 4th floor B side medication refrigerator log was missing temperatures for 4/2/2025 and 4/3/2025. Licensed Practical Nurse #131 stated these dates should not have missing temperatures. It was important to document the temperature daily to ensure proper temperature for the storage of medications. If they were not checked, they could not ensure the temperature was maintained. If a resident was administered medications that were not stored at the proper temperature, the medication might not be effective. During an observation and interview on 4/7/2025 at 7:09 AM, the 3rd floor B side medication room refrigerator was not monitored for appropriate temperature on the temperature log sheet attached to the front of the door on 4/3/2025 and 4/6/2025. Registered Nurse #13 stated they completed the medication refrigerator temperature from the previous night and wrote it on the log sheet for 4/7/2025. The blank date on 4/6/2025 should have been for the night of 4/5/2025. They stated the medication refrigerator needed to be monitored to ensure the medication remained in the required temperature window to work the right way. During an observation and interview on 4/7/2025 at 8:05 AM, the 3rd floor D side medication room refrigerator was not monitored for appropriate temperature on the temperature log sheet attached to the front of the door on 4/1/2025, 4/2/2025, 4/4/2025, and 4/5/2025. The current refrigerator temperature was 27 degrees Fahrenheit and verified by Licensed Practical Nurse #16. The refrigerator included several diabetic medication injection pens and schizophrenia medication injection pen. Licensed Practical Nurse #16 stated they did not know the appropriate temperature range for the medication refrigerator. The evening shift nurse was responsible for completing the temperature log. Improper Storage and Labeling of Medication During an observation and interview on 4/7/2025 at 6:45 AM, the 6th floor B side medication cart had 4 loose pills in the top drawer. Licensed Practical Nurse #12 stated they were assigned the medication cart on the overnight shift. They did not know what the loose pills were, and they did not administer those medications on their shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 4/7/2025 at 7:04 AM, the 3rd floor B side medication cart had fast-acting and long-acting insulin pens for Resident #103 without an open date. Registered Nurse #13 stated the insulin was labeled to make sure it was still effective and not out of date. Insulin should only be used for 30 days after its opened. If there was no date written on the insulin pen, they used the [NAME] date on the label. They stated the [NAME] stood for estimated received date, which met that the pen was received by the facility on that date, so the pen would not have been opened before that date. During an observation and interview on 4/7/2025 at 7:37 AM, the 5th floor B side medication cart had long-acting insulin pens for Resident #95 without an open date. Licensed Practical Nurse #132 stated when the nurse opened the insulin, they were responsible for writing the date on it. The insulin was good for 28 days. They checked the date before giving the medication and if there was no date they discarded it and got a new one. Without the date written on the insulin they had no way of knowing if it was still good, and residents should not get expired medications, it could be less effective. During an observation and interview on 4/7/2025 at 8:11 AM, the 3rd floor D side medication cart had a long-acting insulin pen for Resident #86 without an open date. They stated they did not know when the insulin pen without date was opened. Without a date on the insulin pen they would not know how long the insulin could be used. They only had 30 days to use the insulin, and the medication might not be effective after that date. During an observation and interview on 4/7/2025 at 8:30 AM, the 6th floor C side medication cart had a long-acting insulin pens for Resident #332 and 2 long-acting insulin pens for Resident #74 without an open date. Licensed Practical Nurse #17 stated without an open date they would not know when it was opened, and it was only good for 28 days. If a resident received the medication after the 28 days, the medication might not be effective and could cause high or low blood sugar. The [NAME] stood for earliest refill date. That is the date the nurse could request the pharmacy to restock their prescription medication. They stated that did not use the long-acting insulin on their shift. During an interview on 4/17/2025 at 3:29 PM, the Director of Nursing stated the medication refrigerator temperatures should be 36-46 degrees Fahrenheit and monitored on temperature logs on the refrigerators. If the refrigerator was out of temperature the medication nurse should notify the supervisor and maintenance. The provider and pharmacy should be notified to get replacement medications. Pharmacy Return Medications During an observation and interview on 4/7/2025 at 6:28 AM, the 7th floor medication room had a large pharmacy return bag full of medication blister packs, a large box (approximately 18 inches long by 12 inches wide by 8 inches high) overflowing with medication blister packs, and a stack of medication blister packs leaned against the height of the refrigerator (approximately 3 feet high). Licensed Practical Nurse #14 stated they were not sure when medications were picked up by the pharmacy when they were discontinued or when the resident left the facility. There was no list of medications that were expected to be picked up by pharmacy. During an observation and interview on 4/7/2025 at 8:10 AM, the 4th floor C side medication room had 10 bags of medications to be returned to the pharmacy. Licensed Practice Nurse #52 stated they were not sure how often the medications were picked up by the pharmacy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/16/2025 at 12:19 PM, Registered Nurse Unit Manager #133 stated the discontinued medication went in bags in the medication room and taken to the supervisor's office. They were not sure how often they were taken to the supervisor's office, they usually had the licensed practical nurses on the unit do it. During an interview on 4/16/2025 at 1246 PM, Licensed Practical Nurse #134 stated the extra medications from the medication room were picked up by someone, but they did not know the process for the returning of medications. During an interview on 4/17/2025 at 12:30 PM, the Director of Nursing stated the pharmacy picked up medications daily at 4:00 PM for discontinued medications, dose changes, or residents that passed away. Narcotics were destroyed on Tuesdays with the pharmacy consultant. During a follow up interview on 4/17/2025 at 3:29 PM, the Director of Nursing stated they set the schedule to destroy narcotics. It was a big facility, and they could not destroy/dispose of medications every single day, but the medication nurses knew to bring them to the supervisor's office and not let them pile up. The risk for keeping narcotics in the medication room for an extended period did not change between having only one medication card or multiple. Medication diversion could be a risk when having multiple discontinued medications in the medication room. It was not appropriate to have multiple bags and boxes of expired/discontinued medications remaining in the medication rooms. They should be picked up every day. 10NYCRR 415.18(d)

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	04/18/2025

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48052 48446 48895 Based on observations, interviews, and record review during the recertification and abbreviated (NY00358079 and NY00376311) surveys conducted 4/6/2025-4/18/2025, the facility did not assist residents in obtaining routine and emergency dental care for two (2) of three (3) residents (Residents #102 and #336) reviewed. Specifically, Resident #336 did not receive their dentures as planned and Resident #102 was not scheduled for an outside dental consult for a tooth extraction as recommended by the in-house dentist. Findings include: 1) Resident #336 had diagnoses including dysphagia (difficulty swallowing), obesity, and dehydration. The Minimum Data Set assessment dated [DATE] documented the resident was cognitively intact, was dependent on staff with activities of daily living, did not have broken natural teeth, or mouth pain/discomfort with chewing. The Comprehensive Care Plan revised 4/14/2025 documented an activities of daily living deficit. Interventions included dependency on one staff for assisting with oral hygiene. A 7/18/2024 dental consult completed by Dentist #80 documented the resident wanted full upper dentures. Impressions for full upper dentures would need to be done. During an observation and interview on 4/6/2025 at 10:05 AM, Resident #336 stated they asked several staff to see the dentist and there was no appointment scheduled at this time. They had no upper teeth and needed dentures to chew their food. During an interview on 4/17/2025 at 9:04 AM, [NAME] Clerk #39 stated if a resident saw the in-house dentist all scheduled appointments were made by that department. Resident #336 was seen by the in-house dentist, and all follow up appointments were made by that office directly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/2025 at 9:42 AM, Licensed Practical Nurse #11 stated they were responsible for scheduling appointments for the dental clinic. When a resident was seen, and dentures were recommended they were responsible for scheduling those appointments. Several appointments were required for the impressions, fitting, and making the dentures. When the dentist recommended dentures the next appointment for impressions was scheduled the next time the dentist was in the facility. The dentist was in the facility once or twice a month. After reviewing the medical record Licensed Practical Nurse #11 stated Resident #336 was seen by the dentist on 7/18/2024 and the provider recommended upper dentures. For denture impressions it took 6-8 weeks from the initial appointment to the final appointment where the resident had their dentures. They never scheduled a follow up appointment for impressions because they were waiting to see if the resident was going to remain in the facility for 8 weeks. They did not schedule the appointment because if the resident was discharged before the 8 weeks, they would not be able to complete the fitting. If the resident completed the process and was discharged before the dentures arrived in the facility, they would not know how to get the dentures to the resident. Resident #336 was admitted to long term care and should have started the process for dentures. During an interview on 4/18/2025 at 11:14 AM, Dentist #80 stated when they recommended dentures for a resident, they expected to see them at the next available appointment to start the process for denture fitting. All appointments were scheduled by Licensed Practical Nurse Unit Secretary #11 and started with the impression, then bite registration, then try on, and deliver of the dentures. They stated there was a delay in some dental procedures because equipment was broken, however they did not need that equipment for dentures. It should not take six months or more for a resident to get their dentures. 2) Resident #102 had diagnoses including gastroesophageal reflux disease, anxiety, and dental caries. The Minimum Data Set assessment dated [DATE] documented the resident was cognitively intact, independent with activities of daily living, did not have broken natural teeth, or mouth pain/discomfort with chewing. The 2/21/2025 Comprehensive Care Plan documented a dental care plan. Interventions included monitoring for evidence or oral pain and/or chewing problems, dental evaluation yearly and as needed, and to notify the medical provider for all variance of oral observations. The 2/26/2025 Nurse Practitioner#32 order documented the resident was to receive a dental consult. The 3/7/2025 dental consult documented Resident #102 was seen for complaints of a tooth ache and tooth #18 would need to be extracted. The 3/7/2025 Physician #49 order documented Resident #102 required a dental appointment with an x-ray of tooth #18 for extraction. The 4/2/2025 annual dental exam documented tooth #18 had a cavity and the tooth required extraction. Resident #102 also needed to be seen by the registered dental assistant and hygienist. During an interview on 4/06/25 at 2:45 PM, Resident #102 stated they had not received any dental care, and they stated they have a cracked and rotting tooth. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/09/2025 at 11:33 AM, Licensed Practical Nurse #11 stated the facility dentist does not do extractions. If there was a referral, they would put the order in and then whoever was the ward clerk would set up the appointment with whatever clinic they follow with. Resident #102 was recently seen for their annual exam. The resident needed to be seen by dental hygienist. Tooth #18 had not been extracted, it was a fractured tooth that required extraction, the tooth had broken off. They confirmed there was an order placed on 3/7/2024 for a dental consult. They stated once they put the order in, they do not follow up. During an interview on 4/15/25 at 9:09 AM, [NAME] Clerk #111 stated if a resident had referrals from a dentist, they would get the referral from the Nurse Supervisor or nurse practitioner and send the referral to the dental office. They stated Resident #102 had a referral for a tooth extraction but there was something wrong with their insurance and they were trying to get the resident into a dentist in Rochester. During an interview on 4/16/2025 at 11:41 AM, Resident #102 stated administration was supposed to be assisting them with getting the insurance set up and they would try to send them to Rochester dental. They stated they were in agony with this tooth. 10NYCRR 415.17(b)

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	04/18/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46276 Based on observations and interviews during the recertification survey conducted 4/6/2025-4/18/2025, the facility did not ensure residents were provided food and drink that was palatable, flavorful, and at an appetizing temperature for three (3) of three (3) meals reviewed (Lunch meals on 4/6/2025 and 4/8/2025). Specifically, food was not served at palatable and appetizing temperatures during the lunch meal on 4/6/2025 and two (2) lunch meals on 4/8/2025. Additionally, 12 anonymous residents during a resident council meeting and six (6) residents (Resident #80, 160, 285 336, 355, and 425) interviewed stated the food did not taste good and was cold. Findings include: The undated facility Meal Service Food Temperature Log documented holding temperatures were hot beverages and soups greater than 135 degrees Fahrenheit; hot food items greater than 135 degrees Fahrenheit, and cold food and beverages 45 degrees Fahrenheit or less. If hot food temperatures fell below standards, it must be reheated to 165 degrees F and hold temperature for 15 seconds. During an interview with Resident #336 on 4/6/2025 at 10:05 AM, they stated the food was terrible, lacked flavor, and was not hot. During an interview with Resident #355 on 4/6/2025 at 10:09 AM, they stated the food was not good. During an interview with Resident #285 on 4/6/2025 at 11:46 AM, stated the food was terrible, didn't taste good, and was cold. During an interview with Resident #80 on at 4/6/2025 at 12:06 PM, stated the food was horrible. During an observation on 4/6/2025 at 1:14 PM, Resident #336's meal was tested in the presence of Certified Nurse Aide #55, and a replacement was ordered. Food temperatures were measured as follows: mashed potatoes were 116 degrees Fahrenheit, glazed carrots were 104 degrees Fahrenheit, roast turkey was 116 degrees Fahrenheit, diced pears were 64 degrees Fahrenheit, apple juice was 61 degrees Fahrenheit, and milk was 55 degrees Fahrenheit. During an interview with Resident #160 on 4/7/2025 at 9:08 AM, they stated the food was terrible. During an interview with Ombudsman #101 on 4/7/2025 at 10:11 AM, they stated the food was one of the biggest concerns the residents had. During a resident group meeting on 4/7/2025 at 11:33 AM, 12 anonymous residents stated the food was often cold, did not taste good, was not appealing, and they often had to order take out. During an interview with Resident #80 on 4/8/2025 at 9:29 AM, they stated the food was cold. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/8/2025 the 3rd floor lunch hot food service started at 12:25 PM, at 1:10 PM, the A side food cart (last hallway food cart) started to be plated by food service staff. At 1:15 PM, Food Service Supervisor #59 left the unit to obtain additional ground entree items, and the meal service stopped. The A side meal food cart door was open. Meal service started again at 1:24 PM once the ground food items were brought to the unit and the last tray was plated at 1:33 PM. The meal cart was brought to the A side and nursing staff started passing trays at 1:35 PM, the meal cart door remained opened since 1:15 PM. The last meal tray was passed at 1:50 PM and an extra meal tray was tested for taste and temperature in the presence of the Licensed practical nurse #56. The oven fried chicken measured 107 degrees Fahrenheit, puree rice was 102 degrees Fahrenheit, the puree fruit was 69 degrees Fahrenheit, green beans were 94 degrees Fahrenheit. The food tasted flavorful, but the hot food items were cool. During a meal observation on 4/8/2025 at 1:03 PM, Resident #480's meal tray was tested in the presence of certified nurse aide #56, and a replacement tray was requested. The sliced meat sandwich was 68.4 degrees Fahrenheit, mixed fruit was 71.1 degrees Fahrenheit, apple juice was 66.4 degrees Fahrenheit, ginger ale was 59.5 degrees Fahrenheit, and milk was 63 degrees Fahrenheit. During an interview with Resident Dining Experience Manager #99 on 4/8/2025 at 1:05 PM, they stated residents sometimes would complain the food was cold or did not look good. During an interview with Certified Nurse Aide #51 on 4/9/2025 at 11:19 AM, they stated the residents complained the food didn't taste good. During an interview Licensed Practical Nurse #52 on 4/9/2025 at 11:48 AM, they stated the residents complained the food was cold. During an interview with the Food Service Director on 4/17/25 on 9:45 AM, they stated hot food temperatures should be 140 degrees Fahrenheit and cold food and beverages temperatures 40 degrees Fahrenheit or below. They stated meal trays were plated by the food service department, but the nursing staff were responsible for passing the trays. If the trays were not passed in a timely manner, it could affect the temperature and taste of the food. 10NYCRR 415.14(d)(1)(2) 48446 48895 49448

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	04/18/2025

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 48446 Based on observations, interviews, and record review during the recertification survey conducted from 4/6/2025-4/18/2025, the facility failed to ensure each resident received food that accommodated resident allergies, intolerances, and preferences for three (3) of five (5) (Resident #306, 336, and 704) reviewed. Specifically, Resident #306 was missing food items including their nutritional supplements at meals; Resident #336 was missing food items at meals; and Resident #740 was missing food items including their nutritional supplements at meals. Additionally, 12 anonymous residents during a resident council meeting and five (5) residents (Resident #80, 160, 210, 355, and 480) interviewed stated their meal trays were frequently missing food items. Findings include: The facility policy Fine Dining, revised 3/2025 documented certified nurse aides would serve residents their food per their meal ticket and ensure proper accuracy. Nursing staff would be assigned to deliver and monitor the residents with room trays. 1) Resident #306 had diagnoses including dementia and failure to thrive (a decline in overall health and function). The 3/18/2025 Minimum Data Set assessment documented the resident's cognition was severely impaired, required maximum assistance of 1 with eating, had an unplanned 5% weight loss, and received a mechanically altered diet. On 4/8/2025 at 9:52 AM, Certified Nurse Aide #141 was observed assisting Resident #306 with their breakfast meal in their room. The resident's meal documented they were to receive ground donut holes, fortified orange juice, hot coffee, yogurt, and super cereal. The resident's tray was missing yogurt and coffee. At 1:50 PM, Certified Nurse Aide #141 was observed assisting the resident with their lunch meal in the hallway. The resident's meal ticket documented they were to receive ground beef and rice stuffed pepper casserole, side of gravy, chopped green beans, fruit mix, whole milk, fortified juice, and a health shake. The resident's meal tray did not contain the fortified juice, health shake or side of gravy. On 4/9/2025 at 1:01 PM, the resident's lunch meal ticket documented they were to receive whole milk, health shake, fortified juice, double portions of ground chicken, side of gravy, mashed potatoes, ground broccoli, and magic cup (oral nutrition supplement). They did not receive their fortified juice, double portion of ground chicken, side of gravy, and health shake. 2) Resident #336 was admitted with diagnosis including dysphagia (difficulty swallowing), dehydration, and congestive heart failure. The 3/8/2025 Minimum Data Set assessment documented the resident's cognition was intact and they required supervision with eating. During an interview with Resident #336 on 4/6/2025 at 10:05 AM, they stated their meal trays often had missing items. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During a meal observation on 4/6/2025 at 1:14 PM, certified nurse aide #54 was observed to enter Resident #336 room with their lunch meal. The resident meal ticket documented they were to receive six (6) ounces of roast turkey, gravy, mashed potatoes, glazed carrots, cottage cheese and fruit, fresh oranges, pears, vanilla ice cream, apple juice, and milk. The resident's meal tray only contained two (2) slices of roast turkey and was missing the fruit and cottage cheese, fresh orange, and vanilla ice cream. Certified nurse aide #54 explained to the resident there was no cottage cheese and fruit or vanilla ice cream available and asked if they would like a substitute. They stated their fresh orange was coming up from the kitchen. During an interview on 4/8/2025 at 1:05 PM, Dining Experience Manager #99 stated the residents at times told them they were missing items or not getting the correct portions. They would tell the Director of Nutritional Services so they were aware and could make any changes as needed. During an interview with Licensed Practical Nurse Assistant Unit Manager on 4/16/2025 at 12:12 PM, they stated the residents often complained about missing items and not getting a substitution. If the residents were not getting what was on their meal ticket it could impact their nutritional status. 3) Resident #740 was admitted with diagnoses of Alzheimer's Disease, nausea and weakness. The 4/2/2025 annual Minimum Data Set assessment documented the resident's cognition was intact, required set up assistance with eating, did not have a swallowing disorder and had 5% weight loss not prescribed by a physician. On 4/6/2025 at 1:54 PM, the resident was observed in laying in their bed with their meal tray in front of them. Their meal ticket documented they were to receive roast turkey, mashed potatoes, carrots, fruit cup, yogurt, tomato soup, peanut butter and jelly sandwich, magic cup, (nutrition supplement), and apple juice. They were missing their magic cup and strawberry yogurt. On 4/7/2025 at 10:02 AM, the resident was observed laying in their bed with their meal tray in front of them. Their meal ticket documented they were to receive French toast, sausage, yogurt, milk, and cranberry juice. The did not have their cranberry juice. On 4/8/2025 at 1:44 PM, the resident received their meal tray in their room and their meal ticket documented they were to receive tomato soup and cheese and crackers, which were not on their meal tray. On 4/9/2025 at 1:17 PM, the resident was observed in their room. Their meal ticket documented they were to receive zest chicken, parslied potatoes, pineapple tidbits, peanut butter and jelly sandwich, yogurt, tomato soup, crackers, cola, apple juice, milk and a magic cup. Their meal tray was missing yogurt, tomato soup, and crackers. When asked if staff offered to replace the missing items the resident stated No, because it would not make a difference, they don't get them for you anyways. During an interview on 4/9/2025 at 1:04 PM, Certified Nurse Aide #71 stated the Meal Captains were assigned to check the resident's meal tickets and ensure all items were on the trays. They were the Meal Captain for the south side of the unit. If residents were missing items staff called down to the kitchen to get the replacement. The facility did not have fortified cranberry apple juice, so they just provided the residents with regular apple juice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview with Licensed Practical Nurse Unit Manger #72 on 4/10/2025 11:37 AM, they stated the Meal Captains were to ensure that the meal trays were accurate. They expect staff to notify the kitchen of any missing food items and offer a replacement or alternative if needed. It was important for the residents to receive all the items on their tray including nutritional supplements such as fortified juices. If they did not get the items on their tray it could lead to possible weight loss. During an interview with the Food Service Director on 4/15/2025 at 11:13 AM, they stated there was a national shortage of certain fortified juice products and the facility had not had them in stock for the past 6 weeks. The residents were to receive a different oral nutritional supplement such as ensure or fortified orange juice. It was the nursing staff's responsibility to ensure the residents had all the items listed on their ticket when they passed the meal trays, if there were any missing items staff should call the kitchen for a replacement item. It was important for the residents to receive all their items on their tray to ensure they did have weight loss. 10NYCRR 415.14(d)(3)(4) 48895 49448

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	04/18/2025

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46276 Based on observation, record review and interview during the recertification survey conducted 4/6/2025 - 4/18/2025, the facility failed to ensure suitable, nourishing alternative meals and snacks were provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care for three (3) of five (5) nursing units (Units 3- 7) observed. Specifically, residents did not have snack items available on the nursing units. Findings include: The facility's undated Nourishment Checklist (7 AM - 3 PM) documented to make all sandwiches based on current par levels, ensuring that there was enough for floor stock, cold carts and extras. -Floor stock: 100 sliced meat sandwiches and 100 soft salad sandwiches per day. When completed place sandwiches in the floor stock refrigerator. -Cold Carts: 40 sliced meat sandwiches and 60 soft salad sandwiches per day. When completed place sandwiches on the speed rack (rolling cart) in the floor stock refrigerator. -Restock any cold cart items that are low in stock: applesauce, canned fruit, chef salads, tossed salads, cottage cheese, regular and diet pudding, regular and diet gelatin, orange slices, peanut butter and jelly sandwiches, super pudding, and yogurt. The facility's undated Floor Stock par list documented: -One (1) case of diet and regular cola and ginger ale. -One (1) case each of peanut butter, jelly, diet jelly, loaf of bread. -One (1) box of coffee, decaf coffee, honey thick coffee, nectar thick coffee concentrate, hot cocoa, sugar free hot cocoa, tea bags, decaf tea, nectar thick tea, and honey thick tea. -Two (2) bottles of honey thick and nectar thick water. -One (1) bottle of prune juice, grape juice, apple juice and orange juice. -Three (3) each of eight (8) ounce honey and nectar thick whole milk and chocolate milk. -Six (6) each of four (4) ounce containers of nectar thick and honey thick: apple and orange juices. -Six (6) individual containers of corn flakes and cinnamon toast crunch cereal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	-Eight (8) cartons each of chocolate Ensure (oral nutrition supplement), vanilla Ensure, and mixed berry Ensure. -20 peanut butter and jelly sandwiches, sliced meat sandwiches, and soft salad sandwiches. -18 applesauce cups, 20 soft chocolate chip cookies, two (2) boxes of [NAME] done, one (1) four (4) ounce cottage cheese, 10 individual packages of gold fish, three (3) eight (8) packs of peanut butter cracker sandwiches, nine (9) four (4) ounce fruit cups, five (5) four (4) ounce ice cream cups, six (6) four (4) ounce gelatin and sugar free gelatin cups, 24 four (4) ounce chocolate pudding cups, 20 four (4) ounce vanilla pudding cups, and six (6) four (4) ounce berry yogurts. During a Resident Council Meeting on 4/7/2025 at 11:20 AM, 12 anonymous residents stated the facility they did not receive bedtime snacks and there were no snacks on the units. During an observation on the 5th floor on 4/6/2025 at 1:10 PM, the kitchenette refrigerator had nothing in it. The freezer had ice in a zip lock bag. During an interview on 4/8/2025 at 10:23 PM, Certified Nurse Aide #169 stated the facility said staff were eating the snacks so they got rid of them. The facility used to provide evening snacks with the resident's name on them, but they did not do that anymore. They would hide snacks so residents could have snacks when they requested them. During an observation on the 5th floor on 4/8/2025 at 10:32 PM, the kitchenette refrigerator contained cheese and 1 carton of milk. Certified Nurse Aide #169 stated they did not have the code to the kitchenettes, and they obtained the codes from the dietary department. They took the surveyor to the drink room. The drink room only had to small cases of diet ginger ale and containers of honey and nectar thick juices. During an observation on the 7th floor on 4/10/2025 at 10:51 AM, the kitchenette refrigerator had beverages and 1 container of pudding. During an interview on 4/13/2025 at 8:56 AM, Certified Nurse Aide #172 stated the facility changed the codes to the kitchenettes and they did not know the code and were unable to get snacks when the residents requested them. During an interview on 4/15/2025 at 9:58 AM, Certified Nurse Aide #74 stated the facility used to have snacks for the resident. The snacks were kept in the kitchenettes, but nursing staff did not have the code to the door. They stated some of the staff would take snacks out of the kitchenettes when they were open and place them in the employee refrigerator so they could pass snacks to the residents in the evening. During an and observation on 4/15/2025 at 10:21 AM the 3rd floor employee breakroom refrigerator contained several cartons of milk and ensure, two (2) 1/2 wrapped sandwiches, two (2) packages of cheese and crackers. During an observation on 4/15/2025 at 10:30 AM, on the 3rd floor main kitchenette refrigerator contained one (1) carton of prune juice, two (2) cartons of orange juice, and six (6) 1/2 sandwiches. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	During an interview with the Food Service Director on 4/15/2025 at 11:13 AM, they stated the facility changed the way snacks were handled. Snacks were now stocked on the units so staff could get snacks for the residents as they requested. When the code to the kitchenettes changes they would send out a mass electronic message to the management team with the new code. The unit managers were supposed to alert their staff when the code changed. They felt staff would say they didn't know the code as an excuse to not do what they were supposed to do. The food service department had a staff member scheduled each day to ensure the units were stocked with appropriate par level of snacks and beverages. They stated resident snack items should not be stored with employee food items. During an observation and interview on 4/16/2025 on the 7th floor the kitchenette refrigerator contained 9 peanut butter and jelly sandwiches, 10 packages of [NAME] Doon cookies, and 5 packages of peanut butter crackers. Certified nurse aide #171 stated the code to the kitchenette door often changes and staff must call around to get the code if the dietary staff is not on the unit. 10NYCRR 415.14(f)(3)(4) 48446 48895 49448 r

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	04/18/2025

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 Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43754 Based on observations, record review, and interviews during the recertification survey conducted 4/6/2025-4/18/2025, the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for 1 of 1 main kitchen, and 1 of 2 (Northwest Unit) kitchenette nourishment areas. Specifically, food was held at the improper temperature for service during two (2) meals observed that could have affected all residents, eight (8) of nine (9) handwashing sinks were not properly equipped in the food production and service areas and improper handwashing was observed. Findings include: The facility policy, Fine Dining Policy and Procedure, dated revised 3/2025, did not document temperatures of meals during service. The undated facility Meal Service Food Temperature Log documented the hot food items measured should have been between 135 and 155 degrees Fahrenheit. If they fell below the standard they were to reheat the item to 165 degrees Fahrenheit and document the corrective action. The facility policy, Hand Washing Policy, dated revised 7/2021, documented hands were to have been washed after handing soiled equipment or utensils, during food preparation, as often as necessary to prevent cross contamination when changing tasks, and before donning gloves. The procedure for how to wash hands was documented as the following: - wet hands with warm water (minimum 105 degrees Fahrenheit) and apply antibacterial soap. - rinse thoroughly with clean, running warm water. - dry hands with paper towel. Improper temperature for service - During an observation on 4/7/2025 at 12:25 PM, the 6th floor kitchenette started meal service. The following food items located on the steam table were measured by the surveyor: cooked pasta was 129 degrees Fahrenheit, stewed tomatoes were 109 - 125 degreesFahrenheit, and ground pasta was 125 degrees Fahrenheit. Water in the steam table was measured at 130 degrees Fahrenheit. During an interview on 4/7/25 at 12:28 PM, Dietary Aide #160 who was serving lunch from the 6th floor kitchenette stated they turned the steam table on before service. The food was brought up to the kitchenette in the hot box and then that was plugged in during service to keep the food hot. During service it was transfered to the steam table. They stated everything out for service should have been hot, but they did not measure the temperatures, the supervisors were responsible for measuring the temperatures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 Note: The nursing home is disputing this citation.	During an observation and interview on 4/7/2025 at 1:01 PM, the 7th floor kitchenette was serving lunch. Dietary Aide #177 stated all food was hot on the steam table and they were in the middle of service. The stewed tomatoes were measure at 115 - 136 degrees Fahrenheit. Items in the hot box were measured, pureed chicken was 115 degrees Fahrenheit and cooked bow tie pasta was 124 degrees Fahrenheit. The hot box digital display read 157, but the unit did not appear hold proper temperature. Dining Service Manager #155 came in and checked the temperature of the food on the steam table, but they did not remove any items. Dietary Aide #158 resumed serving the stewed tomatoes from the steam table without any corrective action. During an observation and interview on 4/7/2025 at 1:30 PM, the 3rd floor kitchenette was serving lunch. The following items were measured on the steam table, pureed stewed tomatoes were 120 - 134 degrees Fahrenheit and chicken noodle soup was 128 degrees Fahrenheit. The steam table was missing a wheel in the back and tipped heavily from front to back, only one of the 5 bays had the red light illuminated. Food Service Supervisor #59 stated they heard there was an issue with the stewed tomatoes so they came to help. Dietary Aide #156, who was serving from the 3rd floor kitchenette, stated they did not measure temperatures, that would have been the supervisor and they did not know who that was today. The water was measured under the first bay that held the pureed stewed tomatoes at 136 degrees Fahrenheit, and under the chicken soup was 115 degrees Fahrenheit . During an interview on 4/7/2025 at 2:50 PM, Dining Service Manager #155 stated they were responsible for checking the temperatures on the kitchenettes, but lunch had started before they started their shift today. When checking temperatures, all hot foods should have been above 140 degrees Fahrenheit cold items under 41 degrees Fahrenheit, and those were recorded in a log. They stated Kitchen Manager #179 checked the temperatures before the supervisors checked the temperatures in the kitchenettes. They stated when they checked the temperatures, the noodles on 3 and the stewed tomatoes on every floor were out of temperature. They stated they do not check the temperatures of the food in the hot boxes. For correction the items that they found out of temperature were pulled from service and reheated before they were returned to service. They stated they asked the staff who were serving on the 7th floor if they were done, and they said yes so they left the items out of temperature up there. They stated they should have pulled them and did not realize they resumed serving after they left the kitchen. Dining Service Manager #155 stated it was important the meals were cooked and served at the proper temperatures for the health and safety of the food and the residents liked the food hot. During an interview on 4/7/2025 at 3:03 PM, Sous Chef #180 stated they cooked the stewed tomatoes today. They were cooked to 170 degrees Fahrenheit and then transferred to the hot box in the kitchen. After the tomatoes were identified out of temperature on the units by the surveyor, they noticed the hot box in the kitchen was not plugged in and that was why the tomatoes had cooled off before service. They stated they also discovered at that time that their thermometer was not reading correctly either and they had to get a new one. Sous Chef #180 stated the stewed tomatoes should not have been served for lunch because they were not maintained at a safe temperature, and it was important the meals were cooked and served at the appropriate temperate to keep down bacteria and so the residents got hot food. During an interview on 4/7/2025 at 3:16 PM, Kitchen Manager #179 stated did check the temperatures that morning, but only checked the chicken. They stated they did not check anything else, but they should have. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 Note: The nursing home is disputing this citation.	During an interview on 4/8/2025 at 5:15 PM, Director of Dietary Services #76 stated the meal temperatures were checked by the cooks in the kitchen and again when loaded onto the steam tables for service by a supervisor. The hot foods should have been over 140 degrees Fahrenheit for hot holding and that should have been documented. They stated the stewed tomatoes were out of temperature because the plug was knocked out of the wall and the hot box in the kitchen wasn't working properly in the kitchen. They stated staff should have identified that before service because it was important the food temperatures were maintained properly to prevent food borne illness. Hand wash sinks not properly equipped - The following were observed: - on 4/7/2025 at 11:08 AM, the hand wash sink by dish machine in the kitchen did not have hot water. The foot pedal that controlled the hot water was missing. - on 4/7/2025 at 11:14 AM, the hand wash sink by the windows in the main kitchen did not have soap available. - on 4/7/2025 at 11:15 AM, the hand wash sink by the offices in the main kitchen did not have paper towels. The dispenser handle was broken and towels were not accessible. - on 4/7/2025 at 12:19 PM, the 6th floor kitchenette hand wash sink lacked paper towels. They were visible in the dispenser, but not accessible and did not dispense when tested . The soap dispenser was also not working. - on 4/7/2025 at 12:52 PM, the 5th floor kitchenette soap dispenser was not working and the paper towel dispenser not working. - on 4/7/2025 at 1:01 PM, the 7th floor kitchenette soap dispenser and paper towel dispenser were not working. - on 4/7/2025 at 1:47 PM, the 4th floor kitchenette hand wash sink soap dispenser and paper towel dispenser were not working. - on 4/8/2025 at 12:11 PM, the 6th floor kitchenette hand wash sink did not have soap or paper towels. Dietary Aide #157 did not wash their hands before serving, they just applied gloves. At 12:23 PM they touched the lid of the garbage to dispose of trash, did not change gloves and resumed service. At 12:29 PM they used their gloved hand to serve the fried chicken. - on 4/8/2025 at 12:36 PM, the 5th floor kitchenette did not have hot water, soap, or paper towels at the hand wash sink. - on 4/8/2025 at 12:52 PM, the 4th floor kitchenette hand was sink did not have soap or paper towels available. - on 4/8/2025 at 12:57 PM, the 3rd floor kitchenette hand wash sink did not have paper towels available. At 1:03 PM, Dietary Aide #156 washed their hands, but did not dry them because of the lack of towels available and used a wiping cloth instead. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 Note: The nursing home is disputing this citation.	During an interview on 4/8/2025 at 2:30 PM, Dietary Aide #157 stated they washed their hands in the sink at the back of the kitchenette before, in the middle, and at the end of service. They stated they did not do that today because they forgot, and they were not aware the sink in their kitchenette did not have soap or paper towels available. They stated it was important to wash their hands properly to avoid cross contamination of germs and to keep the area clean for the food service. They stated they should have washed their hands and changed their gloves after they touched the garbage can. During an interview on 4/8/2025 at 2:40 PM, Dietary Aide #156 stated they washed their hands in the sink in the kitchenette. They stated today they did not have paper towels and had to use a washcloth instead, but there should have been paper towels available. They stated they had a group chat they could have used to ask someone to get the paper towels but did not because the washcloth was there. They stated if they didn't have that they would have left the kitchenette to go to the bathroom to wash their hands because it was important their hands were clean while they were serving the food to the residents, everything should have been kept clean, including themselves. During an interview on 4/8/2025 at 4:47 PM, the [NAME] President of Operations #181 stated the facility had a staff person who stocked and cleaned the kitchenettes daily and they should have been checking that the handwash sinks were properly equipped with soap and paper towels. During an interview on 4/8/2025 at 5:15 PM, Director of Dietary Services #76 stated staff were supposed to use any of the 9 hand wash sinks in the main kitchen and kitchenettes to wash their hands. Staff should have had hot water available, soap, and paper towels to properly wash their hands. They stated if any of the facilities lacked any of those items, staff should have reported that to a supervisor and they would send an email to housekeeping. They stated they were not aware that 8 of the 9 sinks available were not properly equipped, but that had been reported to maintenance and housekeeping. 10NYCRR 415.14(h)

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	04/18/2025

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. 48052 Based on observations, record review, and interviews during the recertification survey conducted 4/6/2025 - 4/18/2025, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for six (6) of eight (8) residents (Residents #160, #417, #425, #461, #485, and #790) reviewed. Specifically: - Resident #485 was on contact precautions for clostridium difficile (a resistant contagious bacterium) colitis (inflammation of the colon) and droplet precautions for COVID-19 (a contagious respiratory disease) and did not have the appropriate isolation precaution signs, precautions were not consistently followed, and contaminated laundry items were not separated from general population laundry. - Resident #790 tested positive for COVID-19 on 4/4/2025 and isolation precaution signs were not observed on 4/6/2025. - Resident #417 tested positive for metapneumovirus (respiratory virus) on 4/4/2025 and did not have an isolation precaution sign displayed until 4/7/2025. - Resident #425 tested positive for metapneumovirus and the isolation precaution sign erroneously identified their roommate as being on isolation precautions and isolation precautions were not followed. - Residents #160 and #461 droplet isolation precautions were not followed. - Housekeeper #105 was observed transferring refuse in an unsanitary manner. These practices resulted in the likelihood of serious harm, serious impairment, or death due to the potential transmission of communicable diseases and infections for all 485 residents of the facility. Findings include: The facility policy Infection Control-Policy #1 revised 1/2024, documented the facility would develop prevention, surveillance and control measures to protect residents and staff from institution-acquired infections. The infection control nurse would monitor infection control practices and employee compliance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility policy Infection Control-Policy #3 revised 5/2024, documented three (3) categories of transmission-based precautions: contact precautions, droplet precautions, and airborne precautions. The appropriate sign was to be placed on the resident's door. The contact precaution signs were yellow except for the ones for clostridium difficile colitis (C-diff), which were purple. If a resident was on contact precautions, an effort should be made to utilize disposable items when able and any resident equipment was to be wiped down with the appropriate germicidal wipes upon leaving the room. All personal protective equipment utilized should be removed and disposed of prior to leaving the resident's room. Linen was to be placed into green bags in the bin in the resident's room, tied and then removed and placed in the linen bin in the Soiled Utility Room. Droplet precaution signs were green and were to be placed outside the resident's room. In addition to standard precautions, a mask and eye protection needed to be worn. Staff were to limit movements of the resident outside their room to essential purposes only. The facility policy Infection Control-Policy #14, revised 6/2019, documented residents would be monitored at the first sign of respiratory illness-like symptoms and have exposure to other residents restricted and droplet/contact precautions implemented. The facility policy Infection Control-Policy #17 revised 6/2019, documented for clostridium difficile colitis, contact precautions would be utilized and handwashing with soap and water after glove use was to be done prior to leaving the resident's room. 1) Resident #485 had diagnoses including COVID-19 and enterocolitis (inflammation of the digestive tract) due to clostridium difficile. The 3/16/2025 Minimum Data Set documented the resident had intact cognition and was dependent for toileting hygiene. The resident's bowel continence was not rated. A 4/1/2025 physician order entered by Registered Nurse Unit Manager #9 documented the resident was on contact isolation precautions for diarrhea associated with clostridium difficile. The 4/4/2025 Registered Nurse Unit Manager #9 progress note documented the resident's polymerase chain reaction (a laboratory test) result for COVID-19 was positive. The resident had nasal congestion and a sore throat, was seen by the nurse practitioner, their care plan was updated, and precaution orders were in place. Observations and interviews: - On 4/06/2025 at 10:16 AM, Resident #485 had a contact precaution sign (for the clostridium difficile) on their door however, there was no droplet precaution sign for the COVID-19. Certified Nurse Aide #79 entered the room without personal protective equipment, took the resident's meal tray and touched the bedding, then exited the room without performing hand hygiene. At 10:22 AM, Certified Nurse Aide #106 donned a gown and handed a gown to Certified Nurse Aide #79 before entering the resident's room. Certified Nurse Aide #106 informed Certified Nurse Aide #79 they had to wear a gown due to the resident having clostridium difficile colitis. Both certified nurse aides left the room with their gowns balled up in their hands with gloves on. Certified Nurse Aide #106 disposed of their gown and gloves in the trash can at the nurses' station. They did not perform hand hygiene and walked to the other unit. At 10:24 AM, Certified Nurse Aides #95 and #79 entered the resident's room without donning personal protective equipment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- On 4/06/2025 at 11:39 AM, the resident's room had a droplet/contact precaution sign and a stop sign. Licensed Practical Nurse #17 stated the resident had tested positive for COVID-19 on 4/4/2025, but they did not have the sign posted that morning, so they had [NAME] Clerk #88 get the appropriate sign. - On 4/07/2025 10:28 AM, Physical Therapist #85 entered Resident #485's room and exited the room wearing full personal protective equipment, took a phone call, and paced up and down the short hallway, touching the handrail. Physical Therapist #85 entered and exited Resident #485's room twice to take a phone call and did not change their personal protective equipment. The resident's door was shut during the physical therapy visit. At 10:35 AM, [NAME] Clerk #88 entered the resident's room without personal protective equipment and asked therapy to turn off the call light. At 10:41 AM, Physical Therapist #85 disposed of their personal protective equipment prior to exiting the resident's room with the exception of their N95 mask which they disposed of at the nurses' station. - On 4/07/2025 at 11:10 AM, Registered Nurse Unit Manager #9 entered the resident's room wearing only a surgical mask for protection and was at the resident's bedside. At 11:15 AM, Registered Nurse Unit Manager #9 exited the resident's room, removed their gown, balled it up with gloves on, and carried the balled-up gown, with one glove on, into the soiled utility room down the hall. At 11:40 AM, Certified Nurse Aide #94 entered the resident's room wearing only a surgical mask for protection. - On 4/08/2025 at 10:52 AM, Certified Nurse Aide #96 entered the resident's room wearing a gown, gloves and a surgical mask. Certified Nurse Aide #96 was in the room with the door open and was about to go into the resident's bathroom. They removed one arm from the gown with gloves on. The resident asked for something, and the certified nurse aide went back toward the resident's window and adjusted something. The certified nurse aide entered the resident's bathroom, threw out their gloves and gown, and left the room. When interviewed, Certified Nurse Aide #96 stated they did not wear an N95 mask because there were none in the personal protective equipment caddy. They stated they did not wash their hands in the resident's room, as there were no paper towels. - On 4/08/2025 at 11:27 AM, Physical Therapy Assistant #97 exited the resident's room with the resident's water cup and a to-go container of food, dispensed ice from the communal ice machine into the resident's cup, put the cup on the counter in the unit kitchenette, emptied the to-go container onto a plate, and microwaved the food. Physical Therapy Assistant #97 brought the cup and plate back to the resident and handed it to staff in the room. During an interview at 11:33 AM, Physical Therapy Assistant #97 stated they should not have brought the pitcher out of the room to use communal equipment to refill the cup as items coming out of the resident's room could be contaminated. - On 4/08/2024 at 11:42 AM, Licensed Practical Nurse #98 removed their gloves outside the resident's room and put them in the garbage bag on the housekeeper's cart. They did not wash their hands after removing their gloves and prior to going to the medication cart to access their computer. During an interview Licensed Practical Nurse #98 stated the resident was just on precautions for COVID-19. They were unaware the resident was on precautions for clostridium difficile colitis until they read the resident's orders in the computer and then they went to wash their hands. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- On 4/09/2025 at 4:34 PM, Certified Nurse Aide #100 was in the resident's room with the door partially open. Their hands were ungloved and touching the resident's clothing and linen piled in a chair. They took a roll of garbage bags from inside the room, came to the personal protective equipment door caddy to get gloves, and shut the door. At 4:39 PM, Certified Nurse Aide #100 opened the resident's door wearing personal protective equipment and put a plastic bag with the resident's under-pad and linen and a trash bag with briefs on the ground while they removed their personal protective equipment. They did not wash their hands prior to donning new gloves and picking the trash bags off the ground. They placed the resident's linen bag into the regular laundry bin in the soiled utility room. They washed their hands in the soiled utility which did not have paper towels. At 4:44 PM, Certified Nurse Aide #100 stated the isolation precautions a resident was on were listed on the resident's door. They stated gowns, gloves, a mask, and a face shield should be worn in a droplet precaution room. The linen for Resident #485's room should be put in the red precaution bin inside the dirty utility room. Gloves should always be worn in a contact precaution room and handwashing should be completed after taking off personal protective equipment and prior to leaving the resident's room. Wearing the appropriate personal protective equipment helped prevent the transmission of germs to other employees and residents. During an interview on 4/10/2025 at 11:47 AM, Registered Nurse Unit Manager #9 stated if a resident needed to be on precautions, they checked the labs in the computer to see if a resident had a positive result for whatever was tested . They would put signs on the door, place a precaution order in the computer, and then put in a request for central supply to bring up the personal protective equipment. They went into Resident #485's room with just a surgical mask and not an N95 because they could not locate a N95 mask in the resident's personal protective equipment caddy. If a resident was on precautions for clostridium difficile colitis, the only time the red biohazard bags and bin were utilized was if the resident had items saturated with bowel movements. For residents on precautions for clostridium difficile colitis, staff should wash their hands in the resident's bathroom, put on gloves to take out the trash bags, then wash their hands again in the soiled utility room. If a staff member did not wear the correct personal protective equipment, they could transmit the disease to someone else. 2) Resident #425 had diagnoses including COVID-19, acute cough, and pneumonia. The 1/23/2025 Minimum Data Set assessment documented the resident was cognitively intact. A 4/5/2025 laboratory report documented a specimen sample was collected on 4/3/2025 at 2:00 PM and received by the lab on 4/4/2025 at 3:59 AM. The results were reported on 4/5/2025 at 6:58 AM and human metapneumovirus was detected. A physician order documented droplet isolation precautions for metapneumovirus was discontinued on 4/14/2025. The orders did not include the start date for isolation precautions. During an observation and interview on 4/08/2025 at 9:34 AM, Dietetic Technician #102 entered Resident #425's room without donning personal protective equipment or performing hand hygiene. Dietetic Technician #102 stated they were trained on infection control annually and were familiar with the signs for isolation precautions. The sign on the door documented what personal protective equipment was needed when caring for a resident. They stated they did not see the sign on the resident's door to indicate they were on precautions and did not perform hand hygiene because there was no hand sanitizer outside of the room. If the precaution signs were not followed, they could spread the infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 4/09/2025 at 9:15 AM, Licensed Practical Nurse Assistant Unit Manager #40 stated Resident #425 was on droplet precautions for human metapneumovirus and that it started with their roommate, but the roommate was off droplet precautions as it had been 10 days. The sign on the door documented the precautions were for the resident's roommate, not the resident who was currently on precautions. 3) Resident #461 had diagnoses including cough, fever, pneumonia, and COVID-19. The 1/26/2025 Minimum Data Set assessment documented the resident was cognitively intact. A physician order documented the resident was on isolation contact/droplet precautions pending a polymerase chain reaction (lab test) test for COVID-19. The order was discontinued 4/7/2025 (the resident was hospitalized from 4/7/2025-4/10/2025). The orders did not include the start date for isolation precautions. The 4/7/2025 Nurse Practitioner #48 progress note documented the resident was seen for cough, nasal congestion, and a fever. The plan was a chest x-ray, cough medicine, nebulizer treatment, and a respiratory panel. The 4/7/2025 untimed Registered Nurse Unit Manager #9 progress note documented the resident had a cough and nasal congestion. Lungs with crackles bilaterally. A rapid COVID-19 test swab was done with negative results, a polymerase chain reaction (a laboratory test for COVID-19) was obtained and sent to the laboratory, and a chest x-ray was ordered. During an observation on 4/7/2025 at 10:45 AM, the resident's door had a droplet/contact precaution sign. There was no personal protective equipment outside the resident's room. During an observation on 4/7/2025 at 11:36 AM, Certified Nurse Aide #106 walked into the resident's room to talk to the resident, turned their call light off, and left the room. Certified Nurse Aide #106 did not apply personal protective equipment or perform hand hygiene. 4) Resident #790 had diagnoses of chronic obstructive pulmonary disease (lung disease) and Hodgkin lymphoma (cancer of the lymphatic system). The 3/25/2025 Minimum Data Set documented the resident had intact cognition. The 4/4/2025 Registered Nurse Unit Manager #9 progress note documented the resident was swabbed for COVID-19 and the result was positive. A physician order documented droplet isolation precautions, contact precautions, COVID-19 droplet precautions were discontinued on 4/15/2025. The orders did not include the start date for isolation precautions. During an observation and interview on 4/6/2025 at 10:57 AM, there were no precaution signs posted outside of Resident #790's door and no personal protective equipment caddy hanging on or near the resident's door. There were two gowns on a bedside table outside the resident's room. Certified Nurse Aide #79 stated the resident was not on precautions They thought the resident used to be on precautions but did not think they were presently. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/6/2025 at 11:32 AM, Licensed Practical Nurse #17 stated the resident was on droplet/contact precautions due to testing positive for COVID-19. They were informed yesterday the resident was on precautions, but they did not have a proper sign, so they put up a contact precaution sign that was later removed. Housekeeping: During an observation and interview on 4/9/2025 at 9:19 AM, Housekeeper #105 carried a garbage bag with personal protective equipment slung over their shoulder, down the hallway into the soiled utility at the other end of the hall. They were not wearing personal protective equipment. Housekeeper #105 stated the garbage was from their cart with garbage bags from the resident rooms. The garbage bag became full at the end of the C Unit hallway, which was on precautions for droplet. They stated they did not wait to do the isolation precaution rooms last but emptied the rooms in order. During an interview on 4/10/2025 at 11:12 AM, Housekeeper #143 stated they did not wear personal protective equipment, and all rooms were cleaned the same. They stated they cleaned surfaces with a yellow cleaner with water in a basin and a washcloth. They stated they used to use the same cleaner in the mop bucket, but it messed up the floors, so the mop water was now just plain water in every room. During an interview on 4/10/2025 at 1:02 PM, Housekeeper/Laundry Aide #108 stated there was a bin on each unit for the resident laundry and resident linen. They stated they collected the bins from the unit and then the clothes went into the washer and the dryer. All linen was sent out. They stated they were not told if a resident had an illness. They sometimes got a note on the laundry with the resident's name and to wash the items separately. They wore gloves when the items were removed from the bags, but no other protective equipment. There were no separate water temperatures or different detergents used if someone was sick. Staff were supposed to rinse out any stool prior to putting it into a bag, but that did not always happen. They stated they did not wear personal protective equipment as it was hot in the laundry room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/11/2025 at 10:22 AM, the Infection Preventionist stated they reviewed the labs every morning for residents and then they delegated to the Nurse Managers and told them whom to put on isolation precautions based on that information. Staff were educated on infection control through orientation and yearly competencies. The last education was March 2025. The spread of infection was lessened by housekeeping doing enhanced cleaning with bleach and not floating staff, if possible. Once a resident tested positive for an infectious disease, whoever tested the resident would write a progress note, get a physician's order for isolation precautions, and place the isolation precautions on the care plan. The ward clerk printed out the appropriate isolation precaution sign and made sure the rooms had personal protective equipment. The off-shift nursing supervisor had a folder with the color-coded isolation precaution signs. Purple contact signs were used for residents with clostridium difficile colitis, pink special droplet/contact precaution signs were utilized for COVID-19, and green droplet signs were used for influenza. The isolation sign would designate if it was the window or door bed, if it was a double room. The signs for Residents #417and #790 for COVID-19 and metapneumovirus should have been on the door on 4/6/2025. The risk of not having the appropriate signage was spread of the infection. Staff were expected to wear the personal protective equipment designated on the sign, remove their personal protective equipment prior to exiting the room, and perform proper hand hygiene. Staff should never enter a room on droplet precautions without wearing personal protective equipment. For rooms on contact for clostridium difficile colitis, they let the Housekeeping Director know so they would clean the room last and use bleach. It was also communicated to the direct care staff to use soap and water for hand hygiene and use bleach to clean equipment. Laundry went into a regular linen bag unless it was saturated. Staff should clean their hands with soap and water prior to donning new gloves to carry the linen bag to the soiled utility room. This would limit the spread of infection. Laundry personnel should be wearing gowns and gloves when handling dirty laundry, as there was no way for them to know if they were handling infectious material. During an interview on 4/11/2025 at 10:40 AM, the Medical Director stated isolation precautions should be initiated when the resident became symptomatic. If a resident had respiratory symptoms, they should be on droplet precautions unless the test came back negative. If a resident was positive for COVID-19, influenza, or clostridium difficile colitis, they expected to be notified when the results came back. There should be appropriate signage, so staff knew what personal protective equipment to use. Staff should follow the use of personal protective equipment per policy. If staff were not using the proper personal protective equipment they could spread the infection. Every staff member needed to follow the isolation signage and wear the proper personal protective equipment. During an interview on 4/11/2025 at 10:43 AM, the Administrator stated there was an Infection Preventionist in the facility that led the process for infection control. During morning report, they discussed any infections in the facility. When a resident presented with symptoms, the Registered Nurse Unit Managers or Nursing Supervisor would assess the resident. If the resident required testing, the Infection Preventionist and the Medical Director were informed. The resident should be on precautions from the time they were symptomatic, and precautions only removed if the test was negative. All residents on precautions should have the appropriate sign and personal protective equipment in a caddy on their door. They expected staff to follow the recommendations of personal protective equipment based on the precaution signage and to perform the correct hand hygiene. Residents on precautions for clostridium difficile colitis should have their rooms cleaned with bleach. If proper personal protective equipment was not worn, proper hand hygiene was not done, and the proper chemicals were not used to clean, there was a potential that a disease could spread. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/11/2025 at 11:46 AM, the Director of Nursing stated if a resident had a cough, they should be assessed by nursing, who then reported to medical. The resident would also be placed on precautions in case anything infectious came back from testing. The order for the precautions was put in by either the Infection Preventionist or the Registered Nurse Unit Manager. The signs for the precautions were put up by the ward clerk. If there was no ward clerk on shift, the precaution signs could be placed by the nurse. The door caddy of personal protective equipment was put up by central supply and there were extra personal protective equipment items in the clean utility room. If the resident had a positive result of an infectious disease, there should be the appropriate signage hung. All staff should review the isolation precaution signs prior to entering the room and follow the directions on the sign. If the appropriate sign was not hung or the staff did not wear the correct personal protective equipment, infection could spread. The rooms of residents on precautions for clostridium difficile colitis should be cleaned with bleach. They were unsure how the laundry was separated for a resident on precautions for clostridium difficile colitis, but laundry staff was required to wear personal protective equipment when handling all laundry. 10 NYCRR 415.19(a)(b) ********** The facility was notified of the Immediate Jeopardy on 04/11/2025 at 2:03 PM. The Immediate Jeopardy was removed on 4/15/2025 at 2:40 PM prior to the completion of the survey. The facility implemented the following to remove the immediacy: - Initial plan of immediacy was approved on 4/11/2025 at 4:47 PM and included the facility ensuring all residents on precautions were reviewed and had the appropriate isolation precaution signage in place, all in-house staff were educated on infection control with competency-based training, and all oncoming staff would be educated prior to the start of their shift. - The facility provided in-service education to 85% of staff as of 04/15/25 at 1:25 PM, with plans for ongoing education of staff not currently on the schedule, prior to the start of their next shift. - Multiple interdisciplinary staff were interviewed during onsite visits through 4/15/2025. All staff demonstrated knowledge of the education provided on appropriate infection control precautions. 48446 50561

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	04/18/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48446 Based on observations and interviews during the recertification survey conducted [DATE]-[DATE], the facility did not maintain an effective pest control program so that the facility was free of pests for the administrative area and for 3 of 7 units (3rd, 4th, and 6th floors) reviewed. Specifically, there were fruit flies observed in the administrative area, and the 3rd, 4th, and 6th floors. Findings include: The facility policy, Insect and Rodent Control, revised ,d+[DATE] documented to prevent insect and rodent entry into the facility, the facility would ensure proper cleaning of the facility daily per Centers for Medicare and Medicaid policies and procedures, proper food storage in the facility, ability to identify rodent infestation and notify proper personnel when a rodent infestation was identified. An outside vendor was contracted to manage insect and rodents at the facility and vendor books would be placed at the nursing stations for staff to update and report any sightings. The vendor would follow up with a deep cleaning of the specified area and perform preventative measures as needed. The following observations of multiple fruit flies were made on [DATE]: - at 12:36 PM, in the 6 south dirty utility room. - at 1:03 PM, in Resident #105's room. - at 1:35 PM, in the administrative sitting area outside of the receptionist window area. On [DATE] at 1:44 PM, there were mouse droppings on the floor in Resident #200's room. The following observations of multiple fruit flies were made on ,d+[DATE]//2025: - at 6:25 AM, in room [ROOM NUMBER]. - at 8:56 AM, at the 6th floor North B side nursing station. - at 9:46 AM, in the 3rd floor North side nursing conference area bathroom. - at 11:29 AM, at the 6th floor C side nursing station. - at 1:25 PM, in the 4th floor D side hallway. The following observations of multiple fruit flies were made on [DATE]: - at 10:45 AM, a fruit fly landed on the surveyor's hand at the 6th floor C side nursing station. - at 11:03 AM, at the 6th floor C side nursing station. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- at 11:04 AM, at the 3rd floor C side nursing station. The following observations of multiple fruit flies were made on [DATE]: - at 9:31 AM, at the 6th floor nursing station. - at 9:39 AM, on the floor at the 6th floor nursing station. - at 11:41 AM, in the 4th floor resident kitchen. During an interview on [DATE] at 12:44 PM, Resident #200 stated there were mice in their room that came out at night through the vents. They stated they observed mouse droppings on the floor in their room. During an interview on [DATE] at 11:43 AM, Certified Nurse Aide #138 stated they had not seen fruit flies. If they had they would report to housekeeping and put any sightings in the pest control book for the exterminator to see when they came. They had not seen any mice. All unit staff were responsible for emptying garbage and replacing the bag. Housekeeping was responsible for cleaning floor mats and nursing staff should clean up immediate spills and housekeeping would sanitize after. During an interview on [DATE] at 11:51 AM, Licensed Practical Nurse #6 stated they had not seen any bugs and if they did, they would log it into the pest control book. During an interview on [DATE] at 12:01 PM the 6th floor Housekeeper #107 stated housekeeping was responsible for cleaning dirty dining room tables before and after meals. They had not seen fruit flies or mice and would tell their boss and the unit nurse if they had. During an interview on [DATE] at 12:10 PM, Registered Nurse Unit Manager #91 stated they had not observed any pests. If they did, they would call housekeeping and enter it into the vendor book. The vendor came weekly, and they would also call maintenance for all environmental concerns. During an interview on [DATE] at 1:24 PM, the Interim Director of Housekeeping stated they were aware of the fruit flies. Each unit had a site logbook, and staff should log pests for the pest control expert who came in every Friday and took care of the issue. They were not aware of any mice sightings. During an interview on [DATE] at 1:50 PM, the Director of Dietary stated housekeeping and dietary aides cleaned tables and chairs after the tables were bussed. Dietary staff spot cleaned the kitchenettes and housekeeping cleaned them daily. If fruit flies were observed, they were reported to the vendor when they come every Friday. The Director of Dietary stated there were fruit flies scattered throughout the building on random units. Audits of the kitchenettes were performed weekly, and housekeeping audited the main core dining area, but they were not sure how often. During an interview on [DATE] at 11:40 AM, Certified Nurse Aide #142 state they saw fruit flies occasionally. They had not seen mice or other bugs. They stated if they saw fruit flies they were usually near the food and they would move the trays away and remove the food until the fruit flies were gone. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	04/18/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:16 PM, Resident #179 stated they saw mice in room [ROOM NUMBER] a week or so ago. They stated they reported it to staff but could not recall their names During an interview on [DATE] at 11:32 AM, Licensed Practical Nurse Unit Manager #40 stated rooms should be cleaned and tidied . Sometimes the facility got mice. If mice were observed, they placed a note in the vendor book and maintenance would set a trap. The vendor came once a week. 10 NYCRR: 415.29(j)(5)