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	12/15/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, record review, and interviews conducted during the survey, the facility failed to 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 seven (7) of seven (7) anonymous residents reviewed. Specifically, seven (7) anonymous residents stated staff use foul language, ethnic slurs and laugh at other residents in the hallways and around residents, making them feel uncomfortable.Findings include:The facility policy Dignity and Respect last revised 05/2025, documented residents had the right to be valued as an individual, to be treated with consideration, dignity and respect in full recognition of their self-worth. Residents were to be treated in a manner that enhanced their quality of life, free from humiliation, harassment or threats. Staff were to ensure residents were treated as individuals, provided residents with safe, clean and comfortable surroundings. The undated facility policy Code of Conduct documented that all affected individuals were treated with dignity and respect at all times. Any type of harassment, which included, offensive language or jokes, racial, ethnic, or religious slurs, were prohibited. Residents were to be treated with consideration, curtesy, respect and were sensitive to resident's background, culture, religion and heritage. During an observation on 12/03/2025 at 10:54 AM, Certified Nurse Aide #6 loudly said an ethnic slur in the hallway with staff and three (3) residents present. Multiple resident room doors were open. During an observation on 12/08/2025 at 3:17 PM, Certified Nurse Aide #7 laughed at an unidentified resident while they were confused and screaming in the dining area. Certified Nurse Aide #7 stated enthusiastically that the resident was difficult and laughed while 18 unidentified residents were in dining area. During an interview on 12/03/2025 at 12:41 PM, Resident #12 stated they have heard staff talk about residents in the hallway. They further stated foul language and ethnic slurs were used often by staff and felt that was disgusting and awful. During a group interview on 12/04/2025 at 10:28 AM, seven (7) anonymous residents stated staff cussed and yelled at each other constantly. They stated racial slurs were used all day long by staff, who also made jokes about drug use. During an interview on 12/08/2025 at 3:09 PM, Certified Nurse Aide #6 stated they have heard staff use foul language and ethnic slurs in the hallway. They stated ethnic slurs and cussing should not be said, and that they did not recall having said an ethnic slur in the facility. During an interview on 12/08/2025 at 3:32 PM, Certified Nurse Aide #7 stated they never heard staff members laugh or talk about residents in the hallway. They had a resident that was confused and yelling out but did not believe they laughed or talked about them in the dining area. During an interview on 12/09/2025 at 8:41 AM, Licensed Practical Nurse #6 stated they never heard staff laughing or joking about a resident, at least not recently. Swearing in the hallway or laughing at a resident was not right. It was a dignity issue if staff laughed or made fun of a resident. During an interview on 12/09/2025 at 9:00 AM, Registered Nurse #4 stated they had heard staff swear in the hallway but had not heard staff use ethnic slurs. They further stated that staff should never say ethnic slurs, however, ethnic slurs were part of Black culture and used often. Registered Nurse #4 stated staff forgot not to use ethnic slurs. They stated the facility was the residents' home, and ethnic slurs and swearing made residents uncomfortable. They had not heard staff laugh or talk about (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a resident in the hallway. They further stated laughing and speaking about residents in the hallway made residents uncomfortable, humiliated and belittled; it was not dignified. During an interview on 12/12/2025 at 11:28 AM, Administrator #1 stated human resources recently provided re-education related to code of conduct and appropriate behavior on the floor. They stated that having heard staff used foul language and racial slurs was disappointing and disheartening. 10 New York Code Rules and Regulation 415.5(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews conducted during the survey, the facility failed to provide effective housekeeping and maintenance services on five (5) of five (5) resident units. Specifically, the facility did not ensure that resident rooms and common areas were clean and in good repair.Findings include: During observations on 12/03/2025 from 10:11 AM through 3:00 PM, on 12/04/2025 from 8:31 AM through 9:16 AM, on 12/05/2025 from 8:33 AM through 1:30 PM, on 12/08/2025 from 9:41 AM to 10:34 AM, and on 12/10/2025 at 10:53 AM: Strong urine odors were detected in rooms #555, #566 (two (2) observations), and #671 and in the north elevator lobby area. The toilets in rooms #572, #558, #655, and #671 were soiled with black or brown stain marks in the bowl. The soap dispenser located within the bathroom of room [ROOM NUMBER] was broken, and no soap was available. The paper towel dispenser was empty in rooms #565 and #568. The bedding had brown stains in room [ROOM NUMBER] (two (2) observations). The bedside table was stained with beverage cup marks or a dried brown substance in rooms #558 and #679. The fifth-floor unit A and B shower rooms had toilet paper stuck to the floor, a hairbrush and used washcloth on the shower bed, and the toilet paper dispenser was empty. Soiled linens were on the floor in rooms #555 (two (2) observations), 566, #576, #571, #558, and the fifth-floor shower. Trash, dirt, sticky substances, used surgical gloves, and/or food was found on the floors in rooms #557 (three (3) observations), #558, #559 (two (2) observations), #566, #571 (two (2) observations), #576 (two (2) observations), #581 (three (3) observations), #655, #671, and #675. Floor tiles were broken in room [ROOM NUMBER]. A ceiling tile was missing in room [ROOM NUMBER] (two (2) observations). The thermostat in room [ROOM NUMBER] made a hissing sound (three (3) observations). During an interview on 12/03/2025 at 11:12 AM, Resident #456 stated that the bathrooms were not cleaned, and the shower rooms often had feces in them. During observations on 12/09/2025 from 11:31 AM through 1:03 PM: Windows were soiled with water stains on the seventh-floor unit, sixth floor unit, fifth floor unit, fourth floor unit, and third floor unit. Old tape was on the walls in room [ROOM NUMBER]. The 5C, 6A, 6B, 6C, and 6D nurse's station half-wall enclosures were chipped or cracked. The walls had scrape marks in the 5C nurse station. Window and/or privacy curtains were off the hooks in rooms #428, #454, and #455. The following doors had black marks, scrape marks, and/or drip marks: 7042, 7026, seventh floor central shower room, 313, 353, 4212, 474, and 571. Floors in corridors and resident rooms were soiled in corners, next to walls, and/or at the base of the door frame with dirt, grime, scuff marks, and/or were not swept in the seventh-floor unit ice machine area, third floor unit, fourth floor unit, fifth floor unit and sixth floor unit. Floors had scuff marks and/or were un-swept in room [ROOM NUMBER], fifth floor south corridor, in the corridor by room [ROOM NUMBER], on the sixth floor by elevator #4 & #5, and the corridor between rooms #557 and #558. Floor tiles were chipped in room [ROOM NUMBER], by the 6C nurse station (five (5) each), the corridor by room [ROOM NUMBER] and the corridor by room [ROOM NUMBER]. Brass door guards on the clean utility and soiled utility rooms were tarnished and soiled with drip marks on the third-floor unit, fourth floor unit, fifth floor unit, sixth floor unit and seventh floor unit. Handrails were soiled with grime on the fourth floor and third floor.During an interview on 12/09/2025 at 3:01 PM, Director of Environmental Services #1 stated that in the areas described, they would clean, properly hook curtains, and fill paper towel dispensers. Director of Environmental Services #1 stated that they would contact the maintenance department to have the exterior windows cleaned and to repair the floors and walls where necessary and contact the nursing department to help investigate the odors.During an interview on 12/12/2025 at 11:26 AM, Assistant Administrator #1 stated audits are still in progress, things are in place and are looked at by many staff members. They stated there was a push with housekeeping but there was a fine line between resident choice and preferences, building trust with residents, and identifying hazards that may disrupt their preferences. (continued on next page)

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	335184	A. Building B. Wing	12/15/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	They stated this was also being addressed in a behavioral wellness committee. New York Codes, Rules, and Regulations Title 10 S415.5(h)(4)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and interviews conducted during the survey, the facility failed to ensure services provided by the facility met professional standards of quality. Specifically, medication pass times were broad and carried a risk of over medicating or under medicating five (5) (Residents #1, 7, 11, 98, and 527) of five (5) residents reviewed. This affects all residents receiving medication at the facility. The findings are:Cross reference F 842: Resident Records - Identifiable InformationThe Policy and Procedure titled General Medication Administration dated 05/2025, stated scheduled medications requiring specific time increments for administration were to be administered no more than one (1) hour before or one (1) hour after the ordered time. These medications include but are not limited to insulins, oral antihyperglycemic agents, antibiotics, pain management medications, anti-seizure medications, anti-hypertensives, thyroid medications, and warfarin therapy.The Policy and Procedure titled Medication Administration Times revised 05/2025, stated medications would be administered at the following times:- BID (twice daily) 8:00 AM to 12:00 PM, 5:00 PM - 9:00 PM A and C sides (units);- BID (twice daily) 9:00 AM to 1:00 PM, 6:00 PM - 10:00 PM B and D sides (units);- AC (before meals) 6:30 AM, 10:30 AM, 3:30 PM;- PC (after meals) 10:00 AM, 2:00 PM, 6:00 PM.The Policy and Procedure titled Medication Administration Times revised 05/2025, stated medications that require serum blood levels are not affected by the dosing schedule range with the exception of Dilantin. The National Library of Medicine entry for doxycycline hydrate (an antibiotic medication) administration instructions stated doxycycline should be taken in doses of 100 milligrams every 12 hours and is best taken on an empty stomach at least one (1) hour before or two (2) hours after meals. (https://www.ncbi.nlm.nih.gov/books/NBK555888/)The National Library of Medicine entry for amoxicillin-clavulanate (an antibiotic medication used to treat infections) administration instructions stated amoxicillin-clavulanate needed to be administered at regularly scheduled intervals, generally every eight (8) to 12 hours. (https://www.ncbi.nlm.nih.gov/books/NBK538164/)Medline Plus stated valproic acid (an anticonvulsant medication used to treat schizoaffective disorder) and divalproex sodium (Depakote) were all similar medications and should be taken at around the same times every day. (https://medlineplus.gov/druginfo/meds/a682412.html)Medline Plus stated Apixaban (an anticoagulant) should be taken at around the same times every day. (https://medlineplus.gov/druginfo/meds/a613032.html)Medline Plus stated gabapentin (an anticonvulsant medication also used to treat nerve pain) should be taken at evenly spaced times throughout the day and night and no more than twelve hours should pass between doses. (https://medlineplus.gov/druginfo/meds/a694007.html)Medline Plus stated risperidone (an antipsychotic medication) should be taken at around the same times every day. (https://medlineplus.gov/druginfo/meds/a694007.html)Medline Plus stated levetiracetam (an anti-convulsant medication) should be taken once in the morning and once at night. (https://medlineplus.gov/druginfo/meds/a699059.html)Medline Plus stated carvedilol (an antihypertensive medication) should be taken with food around the same time twice a day. (https://medlineplus.gov/druginfo/meds/a697042.html) Resident #1The Medication Administration Records for November 2025 and December 2025 documented:- Eliquis (Apixaban) oral tablet five (5) milligrams by mouth twice daily. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.- Gabapentin capsule 100 milligrams by mouth twice daily. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.Resident #7The Medication Administration Record for September and October 2025 documented:- Apixaban tablet five (5) milligrams via gastrostomy tube twice daily. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.- Doxycycline hyclate 100 milligrams by mouth twice daily. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.- Risperidone oral tablet one (1) milligram via gastrostomy tube twice daily. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.- Valproic acid syrup 250 milligrams per (continued on next page)

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	335184	A. Building B. Wing	12/15/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	five (5) milliliters twice daily. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.The Medication Administration Records for November 2025 and December 2025 documented:- Apixaban tablet five (5) milligrams via gastrostomy tube twice daily 11/01/2025 to 11/05/2025. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.- Apixaban tablet five (5) milligrams by mouth twice daily staring 11/06/2025. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.- Risperidone oral tablet one (1) milligram via gastrostomy tube twice daily. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.- Valproic acid syrup 250 milligrams per five (5) milliliters via gastrostomy tube twice daily 11/01/2025-11/05/2025. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.- Valproic acid syrup 250 milligrams per five (5) milliliters] by mouth twice daily starting 11/06/2025. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.The Medication Administration Record for December 2025 documented:- Apixaban tablet five (5) milligrams by mouth twice daily. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.- Doxycycline hyclate 100 milligrams by mouth twice daily. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.- Risperidone oral tablet one (1) milligram by mouth tube twice daily. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.- Valproic acid syrup 250 milligrams per five (5) milliliters via gastrostomy tube twice daily by mouth. Medication administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.Resident #11The Medication Administration Record for September 2025 documented:- Amoxicillin and clavulanate tab 875-125 milligrams twice daily. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.- Eliquis oral tablet five (5) milligrams (an anticoagulant) by mouth twice daily. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.- Risperidone oral tablet 0.5 milligrams by mouth twice daily. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.The Medication Administration Records for October 2025, November 2025, and December 2025 documented:- Eliquis oral tablet five (5) milligrams by mouth twice daily. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.- Risperidone oral tablet 0.5 milligrams by mouth twice daily. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.Resident #98The Medication Administration Records for September 2025, October 2025, November 2025, and December 2025 documented:- Keppra (levetiracetam) Oral tablet 500 milligrams by mouth twice daily for epilepsy. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM. Resident #527The Medication Administration for July 2025 and August 2025 documented:- Carvedilol tab 3/125 milligrams 0.50 tablets by mouth twice daily. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.- Depakote Oral tablet delayed release 125 milligrams (an anti-convulsant medication) by mouth twice daily. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.- Eliquis oral tablet 2.5 milligrams by mouth twice daily. The administration times were documented as 5:00 PM to 10:00 PM, and 8:00 AM to 1:00 PM.- Gabapentin capsule 100 milligrams by mouth twice daily. The administration times were documented as 5:00 PM to 10:00 PM and 8:00 AM to 1:00 PM.Record review of the Medication Administration Records noted above revealed they contained broad administration times and did not document the actual time medications were administered. Facility policy allowed medications to be considered on time when administered up to one (1) hour early or late, increasing the risk that medications could be given closer together or farther away than prescribed. These combined practices compromise the ability to track medication passes to ensure appropriate dosing intervals consistent with clinical medical standards.During an interview on 12/08/2025 at 5:30 PM, Administrator #1 stated the facility used extended medication pass times and could be four (4) or six (6) hours per medication pass. They stated the time when medication was administered could not be seen in the electric medical record for any standing order medications. Administrator #1 further stated (continued on next page)

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	335184	A. Building B. Wing	12/15/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	that only for as-needed medications could the actual medication administration time be documented. During an interview on 12/15/2025 at 1:49 PM, Administrator #1 and Director of Nursing #1 stated that they could look back in the medical record for specific times of medication administration for as needed medications only and not for standing orders. 10 New York Codes, Rules, and Regulations 415.11(c)(3)(i)

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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. Based on observation, record review, and interviews conducted during the survey, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice for six (6) (4th floor North Medication Cart C and D; 5th floor North Medication Cart A; 6th floor North Medication Cart C and D; 6th floor North Treatment cart used as a medication cart) of ten (10) medication carts reviewed, and five (5) (3rd floor North Medication Room; 4th floor North Medication Room C and D; 6th floor North Medication Room C and D) of nine (9) medication rooms reviewed. Specifically, (a.) five (5) insulin pens were not labeled and or dated; (b.) medication room refrigerator temperatures were not recorded; (c.) narcotic books were not reconciled each shift; (d.) narcotics were not secured in a double lockbox until use. (e.) a narcotic was not signed out upon administration; (f.) Loose pills were found in medication cart; (g.) three (3) multi-use vial medications had no resident name, open and or expiration dates; (h.) two (2) separate cups of pre-poured medications were found; (i.) three (3) inhalers had no open or expiration dates; (j.) two (2) inhalers and one (1) insulin pen had expired; and (k.) treatment cart was left unlocked and unattended. Findings include:The facility's Policy and Procedure titled Storage of Medication revised 08/2020, documented medications and biologicals are stored safely, securely, and properly, following manufacturers recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Temperature refrigerated: 36 F to 46 F (2 C to 8 C) with a thermometer to allow temperature monitoring and the facility should maintain a temperature log in the storage area to record temperatures at least once per day or in accordance with facility policy. Certain medications or package types, such as Intravenous solutions, multiple dose injectable vials, ophthalmic, nitroglycerin tablets, and blood sugar testing solutions and strips require an expiration date shorter than the manufacturer's expiration date once opened to ensure medication purity and potency. The nurse will check the expiration date of each medication before administering it. No expired medication will be administered to a resident. All expired medications will be removed from the active supply and destroyed in accordance with facility policy, regardless of amount remaining. Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures and humidity.The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.During an observation on 12/10/2025 at 9:12 AM, of the third floor Medication Cart A an unlabeled, undated Lantus Solostar pen was noted to be in the top drawer.During an observation on 12/10/2025 at 10:55 AM, the third floor Northside Medication Room temperature log for the medication refrigerator was not recorded on 12/03/2025, 12/04/2025, and 12/07/2025.During an observation on 12/10/2025 at 10:10AM, the fourth floor Medication Cart D contained a bottle of Meclizine (a medication used to prevent and treat nausea, vomiting, and dizziness associated with motion sickness and certain inner ear conditions) tablets with two (2) open dates of 4/25//2025 and 8/06/2024: one (1) Lantus insulin pen with no opened date or expiration date. Licensed Practical Nurse # 13 was unable to verbalize the manufacturer's shortened expiration date. During an observation on 12/10/2025 at 10:15 AM, the fourth floor Medication Room D refrigerator temperature was 48 degrees Fahrenheit.During an observation on 12/10/2025 at 10:34 AM, the fourth floor Medication Cart C contained, one (1) unlabeled Augmentin (an antibiotic used to treat infections) 875 milligram tablet found with stock medications; one (1) bottle of Artificial Tears Eye Drops; one (1) bottle of Flonase Nasal Spray and one (1) bottle of Deep-Sea Nasal Spray all had no resident name, no opened date and or expiration (continued on next page)

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	335184	A. Building B. Wing	12/15/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dates. There were three (3) unidentifiable loose pills in the bottom of drawer 3. During an observation on 12/10/2025 at 11:10 AM, the 6th floor Medication Cart C contained two (2) unlabeled pre-poured cups of medication, one (1) cup had nine (9) and one-half pills, the second cup contained two (2) pills. There were two (2) Suboxone (a prescription medication used for treating opioid addiction) 8 milligrams and 4 milligrams packets respectively loose in top drawer. There were two (2) Trilogy Inhalers and one (1) Anoro inhaler all with no opened date and or expiration dates. One (1) Lantus insulin pen had no resident name, no opened date or expiration date, another Lantus insulin pen with no opened date or expiration date, and one (1) bottle of Artificial Tears with no opened date or expiration date.During an observation on 12/10/2025 at 11:25 AM, the sixth floor Medication Room C refrigerator did not have a lock; the narcotic box inside of the refrigerator was not affixed to the refrigerator and taken out of the refrigerator for access. The lockbox contained an unopened box of Ozempic (an injectable medication primarly approved for adults with type 2 diabetes - a chronic condition where the body cannot use insulin correctly and sugar builds up in the blood - to impriove blood sugar control and to treat obesity) injections.During an observation on 12/10/2025 at 11:50 AM, the sixth floor Medication Cart D contained one (1) bottle of Timolol eye drops with an opened date of 09/24/2025; one (1) latanoprost eye drops with opened date of 09/19/2024; a bottle of Brimonidine 0.2% and a bottle of Artificial Tears eye drops both with no opened date; one (1) Basaglar insulin pen with an opened date of 10/19/2025. The narcotic count for Xanax (a controlled medication used to treat anxiety and panic disorders) 0.25 milligram count was documented as 11 in the narcotic book while the blister pack contained ten (10) tablets). In addition, the narcotic book did not have two (2) signatures signed off during shift change.During an observation on 12/11/2025 at 9:50 AM, a treatment cart on the sixth floor North Unit was noted to be unlocked and unattended. Residents were noted to be walking by the unlocked, unattended treatment cart.During an interview on 12/10/2025 at 9:12 AM, Licensed Practical Nurse #2 stated they did not know why there was an unlabeled, undated Lantus pen in the medication cart, and they would dispose of it. They stated the temperature log for the medication refrigerator was to be completed by the night shift.During an interview on 12/10/2025 at 10:10AM, Licensed Practical Nurse # 13 stated they were busy and missed signing the narcotic reconciliation sheet upon arrival but stated they did complete shift change count. During an interview on 12/10/2025 at 10:35 AM, Licensed Practical Nurse #17 stated they had just opened and administered eye drops to Resident #298 prior to them leaving for dialysis. They stated they were going to label the eye drops and nasal spray. Licensed Practical Nurse #17 also stated they were running late due to the snowstorm and in their haste did not sign narcotic sheet. They stated it was the responsibility of nurse assigned to the medication cart to ensure it was clean and orderly.During an interview on 12/10/2025 at 10:40 AM, Director of Nursing #1 stated all nursing staff should conduct narcotic count for reconciliation upon arriving and leaving shift and both oncoming and off going staff should sign narcotic book. The only exception would be if a nurse was working a double shift. In that case they would sign at the end of their double shift.During an interview on 12/10/2025 at 11:25 AM, Licensed Practical Nurse #17 stated they were about to pass medications to a resident when they were called away to the front desk for a call. They stated they should have taken the pre-poured medications with them. Licensed Practical Nurse #17 also stated they were going to give Suboxone and put them in top drawer for convenience.During an interview on 12/10/2025 at 11:25 AM, Licensed Practical Nurse #17 stated prior to today, they did not have a lock box in the sixth floor Medication Room C refrigerator. The Director of Nursing stated all narcotics must be double locked with a non-stationary affixed lockbox; they would put in a work order to have narcotic box affixed to refrigerator and locked.During an interview on 12/10/2025 at 11:50 AM, Licensed Practical Nurse #15 stated they administered Xanax 0.25 milligrams previously and did not sign out. They also stated they had never signed narcotic book when starting shift, only upon leaving shift. The Medication Administration Record documented Resident #487 received Xanax 0.25 milligrams during morning medication pass. 10 New York Codes, Rules, and Regulations 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	12/15/2025

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations and interviews conducted during the survey, the facility failed to ensure residents were provided food and drink that was palatable, flavorful, and at an appetizing temperature for two (2) of two (2) meals reviewed (lunch meal on 12/08/2025 and breakfast meal 12/09/2025). Specifically, food was not served at palatable and appetizing temperatures during the lunch meal of 12/08/2025 and breakfast meal on 12/09/2025. Additionally, seven (7) anonymous residents during a resident council meeting and seven (7) residents (Resident's #4, 121, 175, 211, 238, 277, 493) separately interviewed stated the food did not taste good and was cold. Findings include:The 09/2025 revised facility policy Fine Dining Policy and Procedure documented the Certified Nursing Aides would serve the residents their food per meal ticket and would ensure the tray was accurate. The United States Department of Agriculture Food Safety and Inspection Service guide provided by the facility stated hot food would be held at 140 degrees Fahrenheit or warmer and cold food would be held at 40 degrees Fahrenheit or colder. During an interview on 12/03/2025 at 9:24 AM, Resident #277 stated they did not eat the food at the facility because it was overcooked and cold. During an interview on 12/03/2025 at 10:53 AM, Resident #121 stated the meat was tough to chew at times and was very dried out. The following lunch observations were made on 12/03/2025:- At 11:56 AM, Resident #121's tray ticket documented they were to receive one serving of tossed salad, six slices of orange wedges, and mushroom gravy. They did not receive these items during the meal.- At 12:10 PM, Resident #361 received a pureed bright green substance on their tray. Their tray ticket did not document this item (chocolate milk, ensure clear, pureed baked chicken, extra gravy, mashed potatoes, pineapple, and magic cup).- At 12:49 PM, Resident #238 stated their food was cold and did not taste good. During an interview on 12/03/2025 at 3:10 PM, Resident #4 stated the food was rarely hot, which would have helped the food quality. During a resident group meeting on 12/04/2025 at 10:06 AM, seven (7) anonymous residents stated the food was not cooked right, the meat was very dry and tough and was often cold by the time they received their tray, so they ate out or ordered takeout often. During an observation on 12/08/2025 at 12:56 PM, Resident #175's meal was tested, and a replacement meal was ordered. Food temperatures were measured as follows: milk was 46.7 degrees Fahrenheit, grape juice was 46 degrees Fahrenheit, herb baked chicken was 137 degrees Fahrenheit, baked beans were 156 degrees Fahrenheit, and mandarin oranges were 46.1 degrees Fahrenheit. During an interview on 12/09/2025 at 8:18 AM, Resident #211 stated they did not get the items that were on their tray ticket, and the food was always cold because they were served at the end of the line. During an observation on 12/09/2025 at 8:40 AM, Resident #493's meal was tested in the presence of Certified Nurse Aide #14, and a replacement meal was ordered. Food temperatures were measured as follows: milk 51.4 degrees Fahrenheit, orange juice 53.2 degrees Fahrenheit, coffee 115.3 degrees Fahrenheit, health shake 52.2 degrees Fahrenheit, oatmeal 147.6 degrees Fahrenheit, scrambled eggs 110.2 degrees Fahrenheit, oatmeal 147.6 degrees Fahrenheit, super pudding 62.2 degrees Fahrenheit. During an observation on 12/09/2025 at 9:20 AM, Resident #277's meal was tested in the presence of Dietary Technician #1, and a replacement meal was ordered. Food temperatures were measured as follows: pancakes were 93.7 degrees Fahrenheit, hardboiled egg 111.1 degrees Fahrenheit, milk 48 degrees Fahrenheit, orange juice 49.5 degrees Fahrenheit. The pancakes tasted cold and were difficult to chew, the milk tasted warm, and the egg tasted cold. During an interview on 12/10/2025 at 9:45 AM, Certified Nurse Aide #15 stated the residents often complained the food was not hot and they forwarded the food complaints to the dietary server.During an interview on 12/10/2025 at 10:22 AM, Licensed Practical Nurse #14 stated the residents did not like the food because it was too cold, and the residents did not always get the items on their tray tickets. They forwarded the complaints to the food service managers.During an interview on 12/10/2025 at 12:01 PM, Food Service Director #1 stated the hallway carts did not hold food temperatures as much as they should, and the doors were damaged. They stated this was a critical issue they needed to correct, and they were aware there (continued on next page)

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	335184	A. Building B. Wing	12/15/2025

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	were issues with food temperatures in the past. 10 New York Codes, Rules and Regulations 415.14(d)(1)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview conducted during the survey, the facility failed to ensure food was stored, prepared, distributed or served in accordance with professional standards for food service safety for five (5) of five (5) resident unit kitchens and the main kitchen. Specifically, the automatic dishwashing machine was not sanitizing, the chemical sanitizer for manual equipment washing was too concentrated, and equipment and surfaces were not clean and/or in good repair. Findings include:During observations in the main kitchen on 12/03/2025 at 10:07 AM: The automatic dishwashing machine final rinse was zero (0) parts per million of chlorine. The automatic dishwashing machine information data plate stated that the final sanitizing rinse is to be 180 degrees Fahrenheit and provided no instruction for chemical sanitizing. The concentration of quaternary ammonium compound sanitizing chemical utilized in the manual sanitizing of food contact equipment was five hundred (500) parts per million when measured at 68 degrees Fahrenheit. The label directions on the sanitizer concentrate stated that the concentration is to be between 200 and 400 parts per million. The bulk thickener plastic scoop was broken and uncleanable. The walls were in disrepair with missing wall and coving base tiles, old anchor bolts, and old tape. The floor surface coating under the dishwashing machine was broken and peeling up. During observations in the main kitchen on 12/03/2025 at 10:07 AM, the following areas were soiled with food particles, dirt, and/or grime: Table mixer Floor mixer. Sheet pan carts. Shelving. Utensil drawers. Outside of ice machine. Outside of hot food holding carts. Stovetop. Handwashing sinks. Ceiling (dusty). Dry storage area door. Floors in corners and under equipment. Floor drains. Kitchen/housekeeping elevators floors and tracks. Waste receptacles. Mop bucket and wringer. During observations on the third, fourth, fifth, sixth, and seventh floor unit kitchens, pantries, and dining areas on 12/03/2025 at 11:33 AM, the following areas were soiled with food particles, dirt, and/or grime: The underside of all dining room tables (grime, old chewing gum). Beverage dispensers in all cold kitchens (dried tonic concentrate). Cabinet drawers in all pantries. Microwave oven in the fourth-floor pantry. Ice dispensing machine in the fourth-floor dining room. Interior of freezer in the fifth-floor pantry. Floor next to walls and/or under equipment in the fourth-floor cold kitchen and sixth floor cold kitchen & pantry. Interior of refrigerators in the seventh-floor hot kitchen. There was no documented evidence that resident refrigerator temperatures, including Resident #211's refrigerator) were being monitored by facility staff. During an interview on 12/03/2025 at 11:09 AM, Food Service Director #1 stated that the automatic dishwashing machine was converted to a low temperature chemical sanitizing rinse prior to being hired.During a follow up interview on 12/08/2025 at 3:27 PM, Food Service Director #1 stated that they would contact the vendor to adjust the dishwashing machine final rinse, contact the vendor to have sanitizer dispenser to meet the correct concentration, and replace the broken plastic scoop. They further stated they would contact the maintenance department to have the walls and floor repaired, and clean the items found in the main kitchen and unit kitchens and pantries. During an interview on 12/08/2025 at 3:51 PM, Director of Environmental Services #1 stated that they would clean the elevator floor and tracks, and the items found in the unit kitchens and pantries. 10 New York Codes, Rules, and Regulations 415.14(h)

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	335184	A. Building B. Wing	12/15/2025

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interviews during the survey, the facility failed to ensure garbage and refuse was disposed of properly. Specifically, the trash compactor loading area was unclean and heavily soiled. Findings include:During an observation on 12/03/2025 at 10:40 AM, the trash compactor and loading dock area (part of the refuse disposal area) were heavily soiled with black drip marks below the compactor access portal, splash marks and discoloration on the walls, and cobwebs throughout the area. During an interview on 12/08/2025 at 3:45 PM, Director of Environmental Services #1 stated that they would thoroughly clean the trash compactor and loading dock area. 10 New York Codes, Rules, and Regulations 415.14(h)

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	335184	A. Building B. Wing	12/15/2025

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observations and interviews conducted during the survey, the facility failed to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Specifically, administration failed to ensure residents' rights to a safe, clean, comfortable and homelike environment. Administration failed to ensure that their infection prevention and control program was developed and implemented to prevent the spread of infectious diseases for all residents, staff, volunteers, and visitors.Findings include:Refer to F584 Safe/Clean/Comfortable/Homelike environment-S/S-FRefer to F880 Infection Control Prevention-S/S-FRefer to F804 Food Nutritive Value/Appearance, Palatability/Prefer Temperatures-S/S=F Refer to F812 Food Procurement Storage/Prepare/Serve in Sanitary Conditions-S/S=F The facility job description Administrator, undated, documented the Administrator reports to the Corporate Chief Operating Officer and directs all aspects of facility operation in accordance with regulations, standards and guidelines. They oversee facility operations to ensure safety and comfort of all residents and develop and implement and evaluate policies and procedures to ensure the efficient delivery of care and services to the residents. The facility's QAPI (Quality Assurance Performance Improvement) Plan, dated 2025, documented their program will aim for safety and high quality with all clinical interventions and service delivery while emphasizing autonomy, choice, and quality of daily life for residents and family by ensuring data collection tools and monitoring systems are in place and are consistent for proactive analysis, and corrective action. The system to monitor care and services will continuously draw data from multiple sources. These feedback systems will actively incorporate input from staff, residents, families and others as appropriate. The system will track and monitor adverse events that will be investigated every time they occur. Action plans will be implemented to prevent recurrence. Performance improvement project will be a concentrated effort on a particular problem in one (1) area of the nursing center or on a facility wide basis. Changes will be implemented using an organized and systematic process. During an interview on 12/12/2025 at 11:26 AM, Administrator #1 stated Quality Assurance team met monthly, and they determined areas of focus based on previous deficiencies, resident council, employee feedback, family, and current quality assurance reports. They stated based on the last recertification survey deficiency related to the safe/clean/comfortable/homelike environment, they continued to audit the environment. This was ongoing, the facility is big. They have things in place, and this area was looked at by many staff. The previous recertification survey deficiency related to infection control and prevention included a lot of education with staff and residents, including encouraging the influenza vaccination. They further stated they added a layer of monitoring, and infection prevention team meets monthly with the unit managers. During a subsequent interview on 12/15/2025 at 1:49 PM, Administrator #1 stated they were not aware that infection control was still an issue since the last survey. They were not aware of unvaccinated staff still not wearing their masks or wearing them incorrectly. They stated they were aware their facility is a special focus facility per the letter they received on 09/30/2025. They added their infection control list and rate had been shrinking since the last recertification survey. They further stated they recognize where the facility was at and understand they need a higher concentration of compliance, along with education of staff on compliance with all regulations for resident's safety. 10 New York Codes, Rules and Regulations 415.26

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	335184	A. Building B. Wing	12/15/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations, record review, and interviews conducted during the survey, the facility failed to ensure that medical records were kept in accordance with professional standards. Specifically, (a.) documentation for oxygen tubing for Resident #143 was not kept in an accurate and professional record; and (b.) full access to medical records was not granted on request as required by regulation.The findings include:The facility Policy and Procedure titled Oxygen Therapy dated 04/04/2024 stated oxygen tubing was to be changed every two (2) weeks per order and was to be labeled, dated, and documented in the administration record.The Policy and Procedure titled General Medication Administration dated 05/2025 stated all medications and treatments should be documented as administered at the time they are given. Resident #143Resident #143 was admitted to the facility with diagnoses including chronic respiratory failure (when the respiratory system cannot adequately provide oxygen to the body) with hypoxia (when oxygen is insufficient at the tissue level to maintain adequate homeostasis), chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs), and morbid obesity (a severe health condition defined by a Body Mass Index of 40 or greater). The Minimum Data Set (a resident assessment tool) dated 10/29/2025 documented the resident could be understood, could understand others, and was cognitively intact.During an observation on 12/03/2025 at 9:51 AM, the oxygen tubing was noted to be dated 10/01/2025.During an observation on 12/04/2025 at 9:38 AM, the oxygen tubing was noted to be dated 12/01/2025.The Physician Order dated 05/07/2025 documented clean oxygen equipment and change tubing monthly on the 1st and 15th on the day shift.The Treatment Administration Record for October 2025 documented the oxygen tubing was changed on 10/01/2025 and 10/15/2025.The Treatment Administration Record for November 2025 documented the oxygen tubing was changed on 11/01/2025 and 11/15/2025.The Treatment Administration Record for December 2025 documented the oxygen tubing was changed on 12/01/2025.During an interview on 12/03/2025 at 9:51 AM, Resident #143 stated it had been a while since the tubing had been changed.During an interview on 12/04/2025 at 9:38 AM, Licensed Practical Nurse #7 stated they had changed the oxygen tubing on 12/03/2025.During an interview on 12/09/2025 at 12:39 PM, Licensed Practical Nurse #7 stated they were not sure when tubing for oxygen should be changed but that it would pop up on the Treatment Administration Record. They stated there were times they did not change the tubing because they got busy. They stated that earlier that week they had not changed the tubing for Resident #143 but did change it later in the week. They stated they put the date that the tubing was supposed to be changed on the tubing instead of the date it was changed. They stated they were not sure why they had done it and knew they should not have done it. FacilityThe facility did not ensure medical records were made available to surveyors as required by regulation.During an observation on 12/15/2025 at 01:59 PM, the exact times of administration were able to be viewed on Licensed Practical Nurse #18's computer, both as needed and standing orders.In a letter sent to the facility as part of the entrance conference, titled Re: Recertification Survey Entrance Conference, Item #37: Health Electronic Record Access, the facility was made aware they were obligated to provide each surveyor with access to all resident electronic health records and no information should be excluded. This letter was sent to Administrator #1 as part of the entrance conference documents on 12/03/2025.The facility acknowledged the responsibility, locations of records within the electronic medical record, and provided electronic medical record access and laptops on 12/04/2025.Job Description for Administrator, undated, stated the administrator must have extensive knowledge of federal, state, and local regulations regarding nursing home operations.Job Description for Assistant Administrator, undated, stated the assistant administrator must be knowledgeable of laws, regulations, and guidelines pertaining to nursing facility administration (e.g. survey process).Job Description for Director of Nursing, undated, stated the director of nursing must had extensive knowledge of long-term care operations and guidelines.During (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a combined interview on 12/15/2025 at 1:49 PM, Administrator #1 and Director of Nursing #1 stated that the facility was unable to access exact times of medication administrations. They were able to determine if a medication was given within the scheduled time frames or if they were late but could not observe exact times in the residents' medical records except for as-needed medications, not standing orders. During an interview on 12/15/2025 at 1:59 PM, Licensed Practical Nurse #18 stated they had the ability to see the exact time a medication was given for both as needed orders and standing orders.10 New York Codes, Rules, and Regulations 415.22(a)(1-4)

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	335184	A. Building B. Wing	12/15/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observations, record review, and interviews conducted during the survey, the facility failed to ensure a Quality Assessment and Assurance (QAA) committee developed and implemented appropriate plans of action to correct identified quality deficiencies. Specifically, the facility did not implement systems that ensured the care and services it delivered met acceptable standards of quality in accordance with recognized standards of practice. The facility had repeat deficiencies in the areas of Resident Rights (F550), Self-Administration of Medications (F554), Self-determination (F561), Safe/Clean/Comfortable/Homelike Environment (F584), Develop/Implement Comprehensive Care Plans (F656), Quality of Care (F684), Label/Storage of Drugs and Biologicals (F761), Food Nutritive Value/Appearance, Palatability/Prefer Temperatures (F804), Food Procurement Storage/Prepare/Serve in Sanitary Conditions (F812), and Infection Prevention and Control (F880). Findings includeRefer to F550 Resident Rights- S/S-ERefer to F554 Self-Administration of Medications- S/S-DRefer to F561 Self-determination - S/S-DRefer to F584 Safe/Clean/Comfortable/Homelike environment-S/S-FRefer to F761 Label/Storage of Drugs and Biologicals- S/S-ERefer to F804 Food Nutritive Value/Appearance, Palatability/Prefer Temperatures-S/S=F, Refer to F812 Food Procurement Storage/Prepare/Serve in Sanitary Conditions -S/S=ERefer to F880 Infection Control Prevention-S/S-FDuring a record review on 12/11/2025 at 12:26 PM, the last six (6) months of the Quality Assurance meeting sign-in sheets revealed committee members, and the Medical Director had attended each monthly meeting.During a combined interview on 12/12/2025 at 11:26 AM, Administrator #1, Assistant Administrator #1, and Director of Nursing #1 stated the Quality Assurance Committee met monthly. The Medical Director attended at least quarterly but was generally there in person monthly. The committee consisted of the Administrator, the Assistant Administrator, the Director of Nursing, the Medical Director, the Director of Maintenance, the Director of Rehabilitation, the Director of Social Services, a Concierge representative, the Director of Minimum Data Set Assessments, Security representative, Respiratory Therapy representative, the Food Service Director, the Clinical Nutritionist and the Pharmacy Consultant. Other department members attended frequently also, such as environmental services, housekeeping, maintenance, and others as needed. The Administrator stated facility policies were reviewed by the Administrator, Assistant Administrator and department heads on an annual basis and as needed. The committee determined Quality Assurance topics based on previous deficiencies, Resident Council topics, employee feedback, Quality Assurance reports, family and employee satisfaction surveys, grievances, staff rounds, and Ombudsman feedback. Those topics were tracked through committee minutes, performance improvement projects, agenda items, antipsychotic medication rates, medical provider staff meetings, pharmacy consultants, and medication gradual dose reduction meetings. During the interview, the previous survey citations were discussed with continuing facility concerns regarding resident rights, environment issues, misappropriation, care plans, food palatability and temperatures, snacks, food storage, infection prevention and control, and pest control. They stated topics had improved, staff had been added to assist with the process, and audits remained on-going. Administrator #1 and Director of Nursing #1 stated those topics were currently being audited by the facility. Staff education was being done as concerns arose. They were unaware there were concerns with staff language in resident areas or around residents. During an interview on 12/15/2025 at 10:13 AM, Administrator #1 stated good faith efforts to correct previous deficiencies had been put forth. It would take time to get where the facility needed to be. It had not been long since the last survey's plan of correction was accepted, and the facility had been doing their best thus far. During a combined interview on 12/15/2025 at 1:49 PM, Administrator #1 and Director of Nursing #1 stated the facility was unable to access exact times of medication administrations. They were able to determine if a medication was given within the scheduled time (continued on next page)

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	335184	A. Building B. Wing	12/15/2025

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	frames or if they were late but could not observe exact times in the residents' medical records. They were not aware of any infection control issues. They were also not aware that some staff that were not vaccinated for influenza, were not correctly wearing a surgical mask as required during influenza season declared by the New York State Department of Health.10 New York Codes, Rules, and Regulations 415.27(a-c)

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	12/15/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews conducted during the survey, 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 two (2) (Resident #11 and Resident #336) of two (2) residents reviewed. Specifically, Resident #11 and Resident # 336 were observed with their urinary drainage bag on the floor without a barrier separating the floor from the drainage bag; the sink in room [ROOM NUMBER] was not functioning for the duration of the survey, and the resident (Resident #5) in room [ROOM NUMBER] was on enhanced barrier precautions. Additionally, Resident's #11, #64, #467, #478, #542, and #651 were diagnosed with influenza and multiple unvaccinated staff were observed in resident areas not wearing a facemask or wearing a facemask improperly.Findings include:The facility policy Infection Control revised 1/2024 documented the facility was concerned with preventing the development and spread of facility related infections. The goal of the facility was to develop an Infection Control Program that protects residents, health care workers, volunteers, visitors and the community from infection whenever possible. The facility would perform surveillance activities to monitor and investigate causes of infection and manner of spread in order to prevent infection in the facility. The best way to break the transmission phase was through frequent hand washing and good personal hygiene.The facility policy Standard Precautions revised on 05/2025 documented standard precautions were used in the care of all residents regardless of their diagnosis, suspected or confirmed infection status. Standard precautions practices included hand hygiene with anti-microbial or non-antimicrobial soap or alcohol-based hand rub before and after contact with the resident and after contact with items in the resident's room. The facility policy 2024-2025 Prevention and Control of Seasonal Influenza with Vaccine initiated 09/2024 documented influenza was a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and lungs. Some people, such as people 65 years and older, young children, and people with certain health conditions, are at higher risk of influenza complications. The influenza A and B viruses that routinely spread in people are responsible for seasonal epidemics each year. Influenza is spread by droplets when people with influenza cough, sneeze, or talk. Employees will be offered the influenza vaccine at no charge and the date of the vaccination, lot number, person administering the vaccine, site of vaccination, and expiration date will be documented in the employee file. If staff refuses the vaccine, this will be documented on the Employee Informed Consent for Influenza Vaccine. Staff could obtain the influenza vaccination from an outside physician and should bring in documentation to the facility. The facility policy Catheter Management revised 08/01/2022 documented drainage bags were placed below the level of the bladder, dated, and covered. The policy Urostomy Care date reviewed/revised 12/2025, documented the purpose of the policy was to ensure residents with urostomies receive safe, sanitary, person-centered, and clinically appropriate care to prevent infection, ensure proper device function, and protect peristomal (area around stoma) skin integrity. The facility will provide urostomy care that maintains infection control compliance.The New York State declaration that required facilities to ensure health care workers unvaccinated for influenza to wear facemasks in health care settings was released on 12/02/2025. A sign was observed by the elevator on 12/09/2025 at 1:53 PM that documented Attention, employees without a flu vaccine must wear a facemask. Flu shots are available in the clinic on the second floor. Influenza Influenza records were requested for ten (10) random staff and received on 12/08/2025. -Vaccinated: Licensed Practical Nurse #3, Diet Tech #1, Physical Therapist #1, and Certified Nurse Aide #4.-Declined: Social Worker #2 declined the vaccination.-There was no documented evidence regarding influenza vaccination status in employee files for Licensed Practical Nurse #4, Certified Nurse Aide #2, Housekeeper #1, Dietary Aide #1, and Certified Nurse Aide #3. During an observation on 12/03/2025 at 10:56 AM, Certified Nurse Aide #2 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was wearing a facemask covering their mouth only, with nose exposed. During an observation on 12/03/2025 at 12:24 PM, Dietary Aide #1 was observed in the kitchenette on the fifth-floor serving food to 17 residents in the dining room, not wearing a facemask. During an observation on 12/04/2025 at 10:07 AM, Certified Nurse Aide #3 was talking to two (2) other staff at the 5 South nurses' station with their facemask covering their mouth only and nose exposed. During an observation on 12/05/2025 at 11:37 AM, Certified Nurse Aide #3 was in the dining room with their facemask not covering their nose with residents being brought to the area for lunch. Certified Nurse Aide #18 was in the dining room sitting in a chair on their phone wearing a facemask below their chin. Their nose and mouth were not covered, and residents were being brought to the dining room for lunch. During an observation on 12/08/2025 at 8:32 AM, Licensed Practical Nurse #4 walked out of room [ROOM NUMBER], walked down the hall to a room behind the nurse's station, and back to the cart at room [ROOM NUMBER] with their facemask below their chin. The facemask was not covering their nose or mouth. They prepared medications and continued their medication pass with the facemask below their chin. During an observation and interview on 12/08/2025 at 11:30 AM, Housekeeper #1 was in a resident care area with their facemask under their chin. They stated they had not received the influenza vaccine and should have their facemask covering their mouth and nose. During an observation on 12/08/2025 at 12:18 PM, two (2) unidentified dietary aides serving lunch in the fifth floor kitchenette were wearing facemasks below their chin. Their nose and mouth were not covered, and multiple residents were in the dining room. During an observation on 12/08/2025 at 12:20 PM, Licensed Practical Nurse #4 was walking from the fifth-floor south nurses' station to the dining room with the facemask below their chin. During an observation and interview on 12/08/2025 at 12:20 PM, Certified Nurse Aide #3 was in the dining room not wearing a facemask with multiple residents eating lunch in the dining room. Certified Nurse Aide #3 stated they received training on infection control and were recently notified that it was influenza season. During influenza season staff that were not vaccinated had to wear a facemask covering their nose and mouth. Facemasks limited the potential for the spread of influenza to residents. They stated their facemask was below their nose last week because it often fell down, and they had to pull it up all the time. They were not wearing a facemask today because they forgot to put one on. They further stated they should wear a facemask because they were not vaccinated and could spread infection. During an observation and interview on 12/08/2025 at 12:48 PM, Licensed Practical Nurse #15 was at the 5 South nurses station wearing a facemask below their chin. Their mouth and nose were exposed. They stated they received training in infection control and were responsible for making sure unvaccinated Certified Nurse Aides were wearing facemasks and wearing them appropriately. They were unsure how they could complete that task. They were not given a list of unvaccinated staff, therefore did not know how to identify staff that should be wearing a facemask. Facemasks had to be worn covering both the mouth and nose to prevent the spread of infection. Licensed Practical Nurse #15 stated they did not wear their facemask over their nose and mouth because it was difficult for people to hear them. They lowered their facemask when talking to allow residents and staff to hear them better. They should not remove the facemask because they were not vaccinated against influenza and were not properly protecting residents against the spread of infection. Their nose and mouth were exposed for the duration of the interview. During an observation and interview on 12/11/2025 at 9:52 AM, Certified Nurse Aide #19 was talking to an unidentified dietary technician wearing a facemask with their nose exposed. When interviewed they pulled their facemask over their nose and stated they were wearing a facemask because they did not get the influenza vaccine. They were told by the facility to wear a facemask over their nose and mouth to protect residents and staff against influenza. During an observation and interview on 12/11/2025 at 9:51 AM, Licensed Practical Nurse #15 was observed administering medications to residents without a facemask. They stated they had not received the influenza vaccine and should be wearing a facemask. During an observation and interview on 12/11/2025 at 9:59 AM, Housekeeper #1 was in the 5 South resident care area with their facemask under their chin. (continued on next page)

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	335184	A. Building B. Wing	12/15/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	12/10/2025 Licensed Practical Nurse # 16 ordered isolation precautions, and droplet precautions for influenza for Resident #467.The 12/10/2025 assessment by Nurse Practitioner #2 documented Resident #467 had a cough and fatigue. Cough and fatigue likely due to influenza exposure. Due to comorbidities and age. Treated with Xofluza (antiviral used to treat influenza) 40 milligrams for two (2) doses.5.) Resident #651 had diagnoses that included femur fracture, obesity, and chronic congestive heart failure.The nasal swab for Resident #651 sent 12/09/2025 was reported positive for influenza on 12/10/2025.On 12/10/2025 Licensed Practical Nurse #16 ordered isolation precautions, and droplet precautions for influenza for Resident #651.The 12/08/2025 assessment by Nurse Practitioner #1 documented Resident #651 had a cough and nasal congestion. They were around a resident that was positive for influenza. Respiratory swab completed.6.) Resident #11 had diagnoses that included pulmonary embolism (blood clot in the lung), cough, and adult failure to thrive. The nasal swab for Resident #11 sent 12/10/2025 was reported positive for influenza on 12/12/2025.On 12/10/2025 Licensed Practical Nurse # 6 ordered isolation precautions, and droplet precautions for influenza for Resident #11.The 12/08/2025 assessment by Nurse Practitioner #1 documented Resident #11 had a cough and nasal congestion. Developed cough and nasal congestion over the weekend and their roommate was sick also. Ordered a viral respiratory panel and Mucinex (loosens and thins phlegm making it easier to cough) 600 milligrams twice a day for five (5) days. During an interview on 12/11/2025 at 8:54 AM, Registered Nurse Supervisor #5 stated they were responsible for resident assessments, staff assignments, care plans, discipline, communication with families, and management of staff. The were responsible for making sure unvaccinated staff were wearing facemasks properly over their nose and mouth. They did not have a list of staff vaccination status. Urinary Drainage Bags1). Resident #11 was admitted to the facility with diagnoses that included rhabdomyolysis (break down of muscle), obstructive uropathy (blockage prevents urine from flowing), and reflux uropathy (urine flows backward to kidneys). The Minimum Data Set (an assessment tool) dated 11/14/2025 documented the resident was cognitively intact, was dependent for toileting and most transfers, and had an indwelling catheter.The Comprehensive Care Plan for Urinary Catheter revised 03/06/2025 documented the resident required enhanced barrier precautions related to indwelling medical device. Interventions included monitor vital signs, obtain personal protective equipment cart, monitor characteristics of urine, and update as needed to provider. Resident #11 had a urinary catheter; interventions included change catheter as per order, maintain foley patency, evaluate abdomen for any signs and symptoms of urinary retention, keep collection bag below resident's bladder level, foley care every shift, and keep drainage bag covered when out of bed.The 08/19/2025 physician orders documented the foley was to remain in place until a follow up with outpatient urology, maintenance of catheter was to be every day and to change the catheter to a leg bag when the resident was out of bed.The following observations were made:On 12/04/2025 at 9:29 AM, Resident #11's foley catheter bag was on the floor to the right of the bed. Resident #11 stated they were not sure why the bag was on the ground and was not the one who placed it there.On 12/08/2025 at 10:05 AM, Resident #11's foley catheter was hung on the right side of the bed with the bottom of the bag and drainage tube touching the floor.During an interview on 12/08/2025 at 10:38 AM, Licensed Practical Nurse #5 stated foley catheter bags were not to be on the floor. Resident #11 had a foley catheter and the bag was not to be touching the ground.During an interview on 12/08/2025 at 10:39 AM, Certified Nurse Aide #5 stated they were Resident #11's aide for that day. Foley catheter bags were hung on an un-moveable part of the bed with the bag off the floor. Resident #11 had a foley catheter and their bag was not to be touching the floor. Certified Nurse Aide #5 confirmed the foley catheter bag was touching the floor. They further stated they must have placed the bed too low to the floor.During an interview on 12/09/2025 at 9:00 AM, Registered Nurse #4 stated foley catheters were to be hung from an immovable part of the bed and in a privacy bag. Resident #11 had a foley catheter and the bag was not supposed to be on the floor. It was an infection risk. Since Resident #11's bed was so low, they put a basin on the floor and the bag was placed (continued on next page)

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	335184	A. Building B. Wing	12/15/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	inside.2). Resident #336,Resident #336 had diagnoses that included cerebral infarction (stroke), epilepsy (seizure disorder), and a history of bladder cancer. The Minimum Data Set, dated [DATE] documented the resident was cognitively intact and had an ostomy (surgical opening (stoma) in the abdomen for waste to exit the body). The Comprehensive Care Plan dated 10/13/2025 included Resident #336 was admitted with a urostomy (surgical opening for urine to exit the body). The care plan approaches included to assist with urostomy management, change urostomy every three (3) to five (5) days and as needed, attach urinary catheter collection bag to urostomy at night, and detach urinary catheter collection bag from urostomy in the morning. During observations on 12/04/2025 at 8:59 AM, 12/09/2025 at 11:04 AM, and 12/10/2025 at 8:33 AM, Resident #336'surinary catheter collection bag was lying directly on the floor with no barrier. During an interview on 12/09/2025 at 8:11 AM, Registered Nurse #5 stated for infection control purposes, the urinary catheter collection bag should not be lying directly on the floor. They stated the floor was not a clean surface and bacteria could potentially enter the bladder. During an interview on 12/10/2025 at 8:36 AM, Certified Nurse Aide #9 stated the urinary catheter drainage bag should not be directly on the floor secondary to backflow. During an interview on 12/11/2025 at 9:23 AM, Director of Nursing #1 stated the urinary catheter drainage bag should not be placed directly on the floor for infection control purposes. They stated it was a precautionary measure to prevent the potential for bacteria from getting where it doesn't need to be. During an interview on 12/12/2025 at 11:26 AM, Administrator #1 stated staff have been educated on placement of urinary catheter drainage bag and the facility has been performing random weekly audits which includes placement of urinary catheter drainage bags. Broken soap dispenserThe soap dispenser in room [ROOM NUMBER] was observed broken and unable to dispense soap on 12/04/2025 at 8:34 AM and 12/15/2025 at 9:27 AM.During an interview on 12/09/2025 at 3:01 PM, Director of Environmental Services #1 stated that in the areas found, they would clean, properly hook curtains, and fill paper towel dispensers.During an interview on 12/15/2025 at 9:30 AM, Housekeeper #3, viawith an interpreter on the phone, stated they were responsible for filling soap dispensers with soap. Work control was responsible for fixing broken soap dispensers.During an interview on 12/15/2025 at 9:54 AM, Certified Nurse Aide #16 stated handwashing was the most important way to prevent the spread of infection. Housekeeping filled the soap dispensers with soap. If there was a broken soap dispenser, they notified maintenance by completing a work order request. When residents were on enhanced barrier precautions, handwashing was required before entering the room and when leaving. The resident in room [ROOM NUMBER] was on enhanced barrier precautions and staff should wash their hands before entering the room and when leaving. They entered room [ROOM NUMBER] and stated the soap dispenser in the bathroom was broken and they were not sure how long it was broken.During an interview on 12/11/2025 at 10:02 AM, Registered Nurse #5 with Director of Nursing #1 in the room, stated they were the infection control nurse and responsible for antibiotic stewardship, monitoring labs, monitoring infections in the building and identification of how to stop the spread of infection. They were also responsible for monitoring vaccination status of all residents and staff. They offered the influenza vaccine to all staff in the clinic. Influenza was declared prevalent on 12/02/2025 and they sent out a blast text message to all employees educating them to wear a facemask if they were not vaccinated against influenza and offered the vaccine in the clinic. They also notified department heads to monitor staff that were not vaccinated. Initially they stated they provided a list of unvaccinated staff to supervisors, then stated they meant to send it out and did not. Once employees received their influenza vaccine, a green circle sticker was placed on their identification badge. They stated they had everyone's current vaccination status except those that were vaccinated in the last week, they did not put the vaccination status on paper. Influenza was spread through droplets and prevented by wearing a facemask over the nose and mouth, getting vaccinated, and good hand hygiene. They stated they had observed unvaccinated staff not wearing facemasks or wearing them improperly. When they see facemasks not being worn or being worn improperly, they provide education. Some staff had been (continued on next page)

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	335184	A. Building B. Wing	12/15/2025

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	335184	A. Building B. Wing	12/15/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview conducted during the survey, the facility failed to ensure the comprehensive person-centered care plan was implemented to ensure a resident's nursing needs were met for three (3) (Residents #1, #7, and #98) of 38 residents reviewed. Specifically, a.) Resident #1's comprehensive care plan for dementia was not person-centered and there were no care plan addressing activities, b.) Resident #7's comprehensive care plan did not address the use of anticoagulants, and insulin, and c.) Resident #98 did not have a care plan initiated for oxygen use. Findings include: The facility policy titled Care Planning/Care Conference, last reviewed 05/20/2025, documented the purpose of the comprehensive person-centered care plan is developed for each resident to include measurable objectives and timetables to meet a residents' medical, nursing, mental and psychosocial needs. The comprehensive care plan should reflect person-centered care with resident specific interventions and should be reviewed and revised as appropriate upon readmission to the facility, quarterly, annually and with any significant change. Resident #1 Resident #1 was admitted to the facility with the diagnoses of Parkinson's disease (a progressive brain disorder affecting movement), dysphagia (difficulty swallowing food or liquids), and dementia (a group of symptoms affecting memory, thinking, and social abilities). The Minimum Data Set (a resident assessment tool) dated 10/10/2025 documented the resident was understood, could understand others and was cognitively intact. There was no documented evidence of comprehensive care plan addressing activities in place for the resident. The comprehensive care plan titled Cognitive Loss/Dementia dated 09/15/2025 did not include person-centered interventions. The interventions include assess level of involvement, address in a slow quiet manner, maintain calm environment, monitor for changes. The interventions were not resident specific. During an interview on 12/09/2025 at 10:40 AM, Registered Nurse #2 stated care plans should be person-centered with interventions specific to the resident's goals and preferences. They stated they were covering the unit and was not the unit manager and had not been involved in care planning for the resident, but it should be addressed at the next comprehensive care meeting during the month of December 2025. During an interview on 12/11/2025 at 10:54 AM, Director of Recreation #1 stated every resident should have a care plan that addresses recreation needs and preferences. They stated they did not know why there was no care plan for Resident #1. Resident #7 Resident #7 was admitted to the facility with the diagnoses of depression (a serious mood disorder causing a persistent feeling of sadness and changes in how one thinks, sleeps, eats, and acts), diabetes (a condition that happens when blood sugar is too high), and chronic kidney disease-end stage (the final permanent stage of chronic kidney disease - when kidneys are damaged and cannot filter blood well over time). The Minimum Data Set, dated [DATE] documented the resident was cognitively intact, required substantial to maximum assistance with most of their activities of daily living, and had received antidepressants, anticoagulants, and insulin injections on seven (7) of the past seven (7) days; and received dialysis treatments. The 08/21/2025 physician order documented Tresiba (insulin degludec) 100 units/millimeter, in 3-millimeter pen injector, 40 units subcutaneous at bedtime for diabetes. The 11/06/2025 physician orders documented Apixaban tablet 5 milligrams, by mouth twice a day for history of venous thrombosis and embolism (blood clots). The 11/01/2025 through 11/30/2025 and 12/01/2025 through 12/10/2025 medication administration record documented the resident received Apixaban tablet 5 milligrams twice a day for embolism prevention, and Tresiba insulin injection daily at bedtime for diabetes. Review of Resident #7's electronic record on 12/08/2025 of the Comprehensive Care Plan updated on 11/19/2025 documented the resident had diabetes. The goal was for the resident's blood sugar to remain in therapeutic range and interventions included monitor the blood sugar, blood pressure and skin. There was no documentation the resident was on (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications including insulin to treat their diabetes. The Comprehensive Care Plan also documented cardiac care area with potential for complications related to hypertension (high blood pressure), coronary artery disease (heart disease), and hyperlipidemia (high cholesterol). There was no documentation the resident was on an anticoagulant. During an interview on 12/10/2025 at 12:05 PM, Licensed Practical Nurse Unit Manager #8 stated they were able to update care plans, but could not initiate the care plans. During the interview they reviewed the electronic medical record and confirmed Resident #7 had an order for Apixaban which was an anticoagulant. They were not sure why the Apixaban medication was not on the care plan and thought that it should be because the resident was at risk for bleeding while taking this medication. They also confirmed the resident was taking an insulin and was followed by a specialty center for their diabetes and this was not on the current care plan either.During an interview on 12/10/2025 at 2:05 PM, Registered Nurse #5 stated they were the responsible unit manager covering the fourth floor at the current time. They also managed the 5th floor. They stated they received notices from Director of Nursing #1 when a resident care plan meeting was due and after the meeting the care plans should be updated to reflect the current plan of care including high risk medications. Resident #7's last care plan meeting was in September 2025, and their care plan should have been updated at that time and with any new care concerns. They stated the resident was currently receiving an anticoagulant and insulin. They pulled up the electronic record during the interview and demonstrated they had updated the care plan that morning after Licensed Practical Nurse Unit Manager #8 notified them the care plan did not have the high-risk medications including Apixaban and the Tresiba insulin listed. They stated this must have been an oversight, as the resident had been on the medications, and they were not new medications. Resident # 98 was admitted to the facility with the diagnoses of chronic congestive heart failure (the heart cannot pump enough oxygen-rich blood to meet the body's needs, causing blood and fluid to back up); dyspnea (shortness of breath) and spastic hemiplegia affecting left dominant side (uncontrollable muscle stiffness and weakness/paralysis often due to brain damage from causes like stroke). The Minimum Data Set, dated [DATE] documented the resident's cognition was intact, they were able to be understood and be understood by others. The Medication Administration Record for Resident #98 dated 12/2025 documented Oxygen Therapy: Liters/min: 2.00 for acute respiratory failure with hypoxia via nasal cannula, routine check every day - Every Shift Order Date: [DATE]. Record review of nursing progress notes dated 11/21/2025; 11/29/2025 documented resident oxygen at 2 liters per minute; on 12/02/2025 documented resident oxygen at 3 liters per minute.During an observation on 12/03/2025 at 2:14 PM, Resident #98's oxygen concentrator was set at three (3) liters per minute. During an observation on 12/08/2025 at 10:30 AM, Resident #98's oxygen concentrator was set at two and a half (2.5) liters per minute. Resident #98's oxygen nasal canula was partially in nostrils, the oxygen tubing was extended across forehead. Review of the Comprehensive Care Plan dated 10/01/2025 for Resident #98 did not have documented evidence of care plan for oxygen or respiratory therapy. 10 New York Codes, Rules and Regulations 415.11(c)(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	12/15/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observations, record review, and interviews conducted during the survey, the facility failed to provide ongoing programs to support each resident in their choice of activities for two (2) (Resident #15 and #163) of two (2) residents reviewed. Specifically, Resident #15 was not offered meaningful activities that included their interests and preferences, and Resident #163 was not included in activities of their preference. Findings include:The facility policy Activities/Therapeutic Recreation Program Policy effective 10/2025 documented the facility provided a structured and individualized program of activities and therapeutic recreation that meets the interests and enhances the quality of life for residents residing at the facility. Each resident had the opportunity to engage in meaningful activities designed to promote physical, mental, and psychosocial well-being, in accordance with their comprehensive care plan, preferences, and abilities. Resident #15 had diagnoses including cerebral palsy (group of movement disorders), cortical blindness (vision loss from damage to brain's visual processing center, and aphasia (language disorder). The 10/23/2025 Minimum Data Set (a resident assessment tool) documented the resident had severe cognitive impairment, did not have physical or verbal behaviors, did not reject care, had no hearing difficulties, was sometimes understood, sometimes understood others, had adequate vision, and was dependent on staff for all activities of daily living. Resident #15's Comprehensive Care Plan for Activities initiated 05/11/2000 and updated 11/05/2025 documented the resident would have at least 12 leisure activities per month. Interventions included 1:1 activities and the resident would be seated near the front so they could see and hear better. The resident was unable to communicate verbally but would smile, move to music, and turn toward auditory stimuli. They required assistance to get transported to activities and spent much of their day in their room watching television. The All-House activities calendar documented live music on 12/12/2025 at 2:00 PM in the BLR. The BLR room was closed, and the activity was held on the 5th floor. The recreation activity log for October 2025 documented engagement with Resident #15:-On 10/07/2025, floor carts with Recreation Staff #1. -On 10/09/2025, music entertainment with Recreation Staff #2. -Ten (10) 1:1 visits with Recreation Staff #2 from 10/01/2025 through 10/16/2025. There were no documented activities provided in the month of October after 10/16/2025.The recreational activities log for December 2025 documented one (1) entry for 1:1 time with Resident #15 on 12/01/2025. Resident #15 was observed sitting in a chair in their room without music or with the television screen listing icons only on: -12/03/2025 at 10:16 AM -12/04/2025 at 10:03 AM -12/05/2025 at 2:26 PM with a musician singing and playing an instrument down the hall in the dining room. The resident is unable to refuse and required staff to bring them to the activity. -12/10/2025 at 8:51 AM During an interview on 12/08/2025 at 12:25 PM, Certified Nurse Aide #3 stated activities were important to get minds involved and it gave the resident purpose. Sometimes they brought residents to activities, however, relied on the activities department to bring residents to activities. Resident #15 enjoyed watching and listening to cartoons and should have the television turned on when staff got them up in the morning. They were not sure why the television was not on because the night shift got the resident up before the day shift arrived to work. Not having a television or radio on could make someone feel isolated. Resident #163: Resident #163 had diagnoses including chronic pain syndrome, difficulty walking, and schizoaffective disorder (mental illness mixing symptoms of schizophrenia and mood disorder). The 10/29/2025 Minimum Data Set documented the resident had intact cognition, did not have physical or verbal behaviors, did not reject care, did not hallucinate or have delusions, was partial/moderate assistance with toileting, and was substantial/maximum assistance with showering and rolling in bed. Resident #163's Comprehensive Care Plan for activities initiated 02/27/2020 and updated 11/24/2025 documented the resident would have at least 12 leisure activities (enjoyable or relaxing activities done for fun) per month. Interventions included transporting resident to activities of interest as they required transportation to and from activities. They attended a variety of off unit activities and enjoyed socializing with peers. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The undated certified nurse care card documented two (2) caregivers at all times for activities of daily living and transfers , the resident was alert and oriented, their interests included but were not limited to cooking, cards, bingo, music, reading, spiritual circle, television, socials, trivia, word search, puzzles, and pets. They were an active participant in activities. The resident required two (2) people and a mechanical lift to get out of bed. The All-House activities calendar dated December 2025 documented coffee brew in the recreation room on: -12/03/2025 at 10:00 AM, 12/05/2025 at 10:00 AM, 12/06/2025, 12/09/2025 at 10:00 AM, 12/10/2025 at 10:00 AM, 12/12/2025 at 10:00 AM. Resident #163 did not attend coffee brew on any of the listed dates. During an observation and interview on 12/03/2025 at 10:04 AM, Resident #163 was in bed and stated they were upset because they liked to go to activities and staff did not get them up in time for morning activities. They especially loved BINGO and coffee hour and missed coffee hour every day because staff did not get them up in time. During an observation and interview on 12/04/2025 at 9:38 AM, Resident #163 was in bed. They stated they were upset because they missed coffee hour and BINGO on 12/03/2025 because staff did not get them up. They wanted to go to the activities and had told staff numerous times, especially Certified Nurse Aide #20. Certified Nurse Aide #20 told them they had to wait until breakfast was served and all trays were picked up before they could get up which was why they missed activities. During an observation and interview at 12/05/2025 at 8:35 AM, Resident #163 was in bed. They were upset that they missed coffee hour on 12/04/2025, an activity that was before BINGO. They stated they were up by 10:00 AM and were able to participate in BINGO on 12/04/2025. During an observation and interview on 12/09/2025 at 12:38 PM, Resident #163 was sitting in their wheelchair. They stated they missed coffee hour again and were upset because they like to socialize with friends. They stated Certified Nurse Aide #20 got them out of bed around 10:00 AM. During an interview on 12/08/2025 at 12:48 PM, Licensed Practical Nurse #4 stated the activities department was responsible for scheduling and coordinating activities, so residents were not sitting around all day and to keep them busy. They had never seen Resident #15 at any activity as they were usually in their room. They were not sure why the resident was not brought to activities unless they did not do well in group settings. If they were not in an activity, they should have their television on for stimulation. During an interview on 12/09/2025 at 11:25 AM, Recreation Therapist #2 stated they were responsible for coordinating and conducting activities on the fifth floor. Activities improved the quality of life for residents. Leisure was good for cognitive, mental, physical, and social wellbeing and activities brought joy to the residents. When the activity was completed, they logged attendance into the electronic medical record. Resident #15 went to most group activities to get out of their room. Resident #15 enjoyed music and was not able refuse to attend activities. They liked residents to attend 12 activities in the month. The completed one 1:1 visit this month with Resident #15, however could not recall the activity or day of the visit. There was live music on 12/12/2025 on the fifth floor and Resident #15 should have been brought to the activity. They were not sure why the resident was not brought to the activity as they were not working that day. During an interview on 12/09/2025 at 11:37 AM, Assistant Director of Therapeutic Activities #1 stated they coordinated entertainment, completed the staff schedule, and helped run activities. Activities were important for well-being, made the day meaningful, brought quality of life and gave residents something to do. Activities occupied time gave something to look forward to and gave a sense of belonging and meaning. Each floor had a leader assigned to each unit. Resident #163 loved all activities and often called the activities department asking to be included in the activity. They stated residents should not have to call the activities department asking to come to activities. Resident #163 especially loved BINGO, happy hour, music, order out and many more. When Resident #163 called activities to come to an activity, the department notified nursing. There were times Resident #163 was in bed and wanted to come to an activity and activity staff notified nursing. They were not sure what activities Resident #15 enjoyed and stated the resident should be included in activities especially music for stimulation. During an interview on 12/09/2025 at 11:53 AM, Recreation Therapist #2 stated Resident #163 loved (continued on next page)

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	335184	A. Building B. Wing	12/15/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	BINGO, food programs, cooking, happy hour, and spiritual group. There were times the resident wanted to go to an activity and was not out of bed. They asked the certified nurse aides to get them up but there were times the resident missed activities they wanted to attend. There was BINGO on the seventh floor on 12/04/2025 and if the resident attended, it was documented in their medical record. During an interview on 12/09/2025 at 12:39 PM, Licensed Practical Nurse #7 stated it was important for residents to attend activities, so they did not feel secluded, and it was how they socialized. Resident #15 had their morning care, was dressed, and moved to their chair by the night shift staff. The night shift should turn the television on for stimulation. Residents missed activities at times because certified nurse aides did not get them up in time for the activity. They overheard certified nurse aides tell residents they could not get up until after breakfast trays were delivered and picked up, which often caused Resident #163 to miss an activity they wanted to attend. Additionally, on multiple occasions, they heard certified nurse aides tell Resident #163 they could not find a transfer sling, which caused the resident to remain in bed and miss the activity. They told Resident #163 to discuss their concerns about missed activities with the Registered Nurse Supervisor #5. During an interview on 12/10/2025 at 9:03 AM, Certified Nurse Aide #20 stated they were responsible for getting residents washed, dressed, and out of bed. Activities were important because the resident was away from home and had no freedom which could cause depression in some residents. Getting to an activity could prevent depression and allowed residents to interact with each other. Resident #163 loved attending activities, however required a lift pad to get them out of bed. Often, Certified Nurse Aide #20 was unable to locate a lift pad which delayed getting the resident out of bed. Resident #163 enjoyed coffee hour and missed coffee hour on 12/09/2025 as they were not up until after 10:00 AM. During an interview on 12/11/2025 at 8:54 AM, Registered Nurse Supervisor #5 stated they were responsible for monitoring care for residents on the fifth floor. Activities were the most important thing for residents as they had something to do, promoted socialization and prevented falls. They had not seen Resident #15 in group activities often and had rarely seen their television on. They should have their television on to prevent isolation and promote socialization. Resident #15 was unable to ask to go to activities because they were nonverbal, however was observed by Registered Nurse Supervisor #5 at a music activity recently where they thought the resident enjoyed themselves. They stated Resident #163 often complained about not being up in times for activities. There were some residents who got up on the night shift, however Resident #163 was not one of them. They had never thought to ask Resident #163 if they wanted to get up earlier. 10 New York Codes, Rules, and Regulations 415.5(f)(1)

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	335184	A. Building B. Wing	12/15/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during the survey, the facility failed to ensure that residents with limited mobility received the appropriate services, equipment, and assistance to maintain mobility and prevent complications for two (2) (Residents #15 and #301) of two (2) residents reviewed. Specifically, Resident #15 did not consistently receive a hand device (palm guard) to right hand and Resident #301 did not consistently receive a rolled cloth to left hand for hand contractures (shortening of the muscles, tendons, and skin) to prevent complications per Occupational Therapy recommendations and as ordered by the physician.Findings include: The facility policy titled Splints revised 11/2025, documented the Occupational Therapy department will evaluate the resident to determine need for splinting and determine type of splint to be used. An order recommendation will be written stating instructions to nursing staff on application, length of time it is to be worn, and precautions.Resident #15 was admitted to facility with diagnoses including cerebral palsy (group of movement disorders), cortical blindness (a vision loss due to damage in the brain's visual processing center), and contracture unspecified joint (restricted movement). The Minimum Data Set (a resident assessment tool) dated 10/23/2025 documented the resident had severe cognitive impairment, did not have physical or verbal behaviors, did not reject care, was dependent on staff for all activities of daily living, and did not receive physical or occupational therapy. Resident #15's Comprehensive Care Plan initiated 05/11/2000 and updated 09/18/2025 documented the resident was dependent for all activities of daily living. They required two (2) assist for hygiene and transferring and one (1) assist for feeding. They had decreased muscle strength and coordination and interventions included maintaining current level of performance. There was no documented evidence of the palm guard intervention in the care plan. The 02/24/2024 physician's order by Nurse Practitioner #1 documented palm grip to the right hand put on after morning care and remove at night.The undated certified nurse aide Care Card (guide for providing care to a resident) reviewed 12/04/2025 documented the resident wore a palm grip in the right hand.The treatment administration record did not have documented evidence of palm guard use.Resident #15 was observed in their room in a chair with both hands contracted, right greater than left. There was no palm guard observed in their right hand on:-12/03/2025 at 10:16 AM-12/04/2025 at 10:03 AM-12/05/2025 at 8:43 AM and 2:06 PM-12/08/2025 at 8:32 AM-12/10/2025 at 8:51 AMDuring an interview on 12/08/2025 at 12:25 PM, Certified Nurse Aide #3 stated residents used splints or palm guards to assist with prevention or worsening of contractures. Palm guards were applied by nurses and if not applied the resident could get worsening contractures. They had cared for Resident #15 numerous times, and they had contractures of both hands. They had never observed Resident #15 wearing splints or palm guards.During an interview on 12/08/2025 at 10:36 AM, Occupational Therapist #2 stated they completed an assessment on every resident upon admission. They stated palm guards were recommended for residents to maintain skin integrity (do not want nails digging into palm) or to decrease the risk for contractures. They further stated that they expected the resident to have the palm guard placed in the right hand every day and were not sure why it was not being used. During an interview on 12/08/2025 at 12:48 PM, Licensed Practical Nurse #4 stated they knew what care residents required by looking at the individual's care plan. Care plans were completed by a registered nurse. Splints and palm guards were used to prevent contractures and applied by the certified nurse aides completing care for the resident, unless it was noted on the treatment administration record. If it was documented on the treatment administration record the licensed practical nurse would apply the palm guard. They stated Resident #15 did not have a palm guard on and was not sure why it was not placed. During an interview on 12/09/2025 at 12:39 PM, Licensed Practical Nurse #7 stated splints and palm guards were normally ordered by the physician when a resident was at risk for (continued on next page)

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	335184	A. Building B. Wing	12/15/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	developing contractures or to prevent worsening contractures. Splints and palm guards were documented on the care plan, and the care plans were completed by a registered nurse. Splints and palm guards were documented on the treatment administration record. They were familiar with Resident #15 and provided care for them for years. Resident #15 trialed a palm guard months ago, however, did not have a current order for a palm guard and it is not on their care plan. They have not applied palm guards or seen palm guards since the trial period months ago. During an interview on 12/11/2025 8:54 AM, Registered Nurse Supervisor #5 stated if a splint or palm guard was ordered by the physician, it was documented on the care plan. They were responsible for updating the care plan. They did not believe splints or palm guards were documented on the treatment administration record. Palm guards and splints were ordered to prevent nail beds from digging into the palm and causing skin breakdown. They could also be ordered to prevent contractures or worsening of contractures. If splints or palm guards were ordered and not applied the resident could get worsening contractures or skin breakdown. Certified nurse aides were responsible for applying splints or palm guards. They were not sure if Resident #15 had an order for palm guards and had never seen them using palm guards. Resident #15 did have contractures of their hands. After looking in the computer, Registered Nurse Supervisor #5 stated the resident had an order for palm guard to the right hand and was not wearing them because staff was not aware of the order. Resident #301 was admitted to the facility with diagnoses including left hemiplegia (one sided paralysis), epilepsy (seizure disorder), and anxiety. The Minimum Data Set, dated [DATE] documented the resident had moderate cognitive impairment and did not exhibit rejections of care.The active physician's orders reviewed on 12/08/2025 included rolled washcloth to left hand, off for hygiene.The Comprehensive Care Plan for Behaviors included the following documentation dated 12/09/2025 1:08 PM: Resident has an elongated nail on the left contracted hand, which they insist on keeping long. On assessment there are no wounds to the contracted hand, and the resident has range of motion to the fingers. Therapy consulted with regard to Occupational Therapy order for washcloth. The physician orders dated 12/09/2025 included the rolled washcloth to left hand had been discontinued at 9:33 PM.The 12/09/2025 Occupational Therapy note documented resident was referred for evaluation of appropriateness of washcloth in left hand. Trialed and assessed for tolerance of carrot (cone-shaped hand contracture device) in left hand. The December 2025 Medication Administration Record and December 2025 Treatment Administration Record did not have documented evidence of the physician order for a rolled washcloth to Resident #301's left hand. During an observation on 12/03/2025 at 3:02 PM, intermittent observations on 12/08/2025 between 8:36 AM and 2:17 PM, and an observation on 12/09/2025 at 10:46 AM, there was no rolled washcloth in Resident #301's left hand. During an interview on 12/09/2025 at 10:47 AM, Certified Nurse Aide #10 stated they were the assigned aide for Resident #301, they checked the care plan in the electronic medical record, and the resident did not have any recommendations to place a rolled washcloth in the left hand. During an interview on 12/09/2025 at 10:54 AM, Licensed Practical Nurse #9 stated they were floated to the unit and were unfamiliar with Resident #301 or if the resident required a rolled washcloth to left hand. During an interview on 12/09/2025 at 10:57 AM, Registered Nurse #5 stated the recommendation for the rolled washcloth to Resident #301's left hand was on the Care Card (guide for providing care to a resident). During an interview on 12/09/2025 at 11:14 AM, Occupational Therapist #1 stated Resident #301 had significant hemiplegia on their left side, a palm guard had been offered to the resident, but the resident refused. Occupational Therapist #1 stated they recommended a rolled washcloth to the left hand to protect skin integrity. Additionally, Occupational Therapist #1 stated there had not been any communication from the nursing department regarding any refusals of the rolled washcloth to the left hand. During an observation/interview on 12/09/2025 at 11:26 AM, Occupational Therapist #2 was observed stretching Resident #301's left hand, the nails on the residents left hand were observed long and jagged, and there was a foul odor coming from the left palm. Occupational Therapist #2 stated Resident #301's left hand needed to be cleansed, and nails filed. Additionally, nursing should be (continued on next page)

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	335184	A. Building B. Wing	12/15/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cleaning the hand daily, monitoring skin integrity, and documenting application/refusals. During an interview on 12/11/2025 at 9:25 AM, Director of Nursing #1 stated residents were assessed by the therapy department for adaptive equipment/devices, recommendations were placed, the medical provider confirms the recommendations, the recommendations are care planned and reassessed as needed. If a resident refused adaptive equipment/devices, education would be provided and if refusals continue, noncompliance would be documented in the care plan. 10 New York Codes, Rules, and Regulations 415.12(e)(2)

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	335184	A. Building B. Wing	12/15/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, record review, and interview during the survey, the facility failed ensure residents who required dialysis services, received such services consistent with professional standards of practice for one (1) (Resident #14) of one (1) resident reviewed for dialysis. Specifically, Resident #14 received hemodialysis treatments at a community-based dialysis center and did not have on-going assessments and oversight before and/or after dialysis treatments. Findings include:Resident #14 was admitted to the facility with diagnoses of end stage renal disease (kidneys no longer work as they should), status post sepsis (a serious condition in which the body responds improperly to an infection), and congestive heart failure (long-term condition that happens when your heart cannot pump blood well enough to give your body a normal supply). The Minimum Data Set (a resident assessment tool) dated 11/28/2025, documented resident was cognitively intact, could be understood, and understand others. The facility's policy and procedure titled; Dialysis, reviewed 08/2025, documented residents requiring hemodialysis therapy would be transported to and from the local Renal Center for dialysis therapy. A dialysis notebook shall be established for each resident receiving dialysis. A facility pre and post dialysis assessment would be completed and documented in the electronic medical record. The Renal Insufficiency/Renal Failure/End Stage Renal Disease Care Plan initiated 10/15/2025 documented the resident needed dialysis related to end stage renal disease. Interventions included the resident would be free of complications from dialysis through review date; monitor/document access site every shift and communicate with dialysis center via notebook. The December 2025 Treatment Administration Record documented a physician order that the resident was to attend dialysis on Monday, Wednesday, and Friday; and to monitor arteriovenous fistula/access site (irregular connection between an artery and a vein) left arm every shift. There was no documented evidence of monitoring on12/01/2025, day shift, 12/04/2025 evening shift, 12/05/2025 evening or night shift, 12/06/2025 evening shift, 12/07/2025 night shift, 12/08/2025 evening shift, 12/11/2025 evening or night shift, 12/12/2025 day or evening shift, 12/13/2025 evening shift, or 12/13/2025 evening shift. Review of record provided dialysis communication notebook dated 11/12/2025 to 12/09/2025 did not have documented evidence of post-dialysis vital signs, weights, evaluation of the dialysis access site, or a signature for 11/12/2025, 11/17/2025, 12/01/2025. There was no documented evidence of pre or post dialysis documentation for 11/14/2025, 11/21/2025, 11/24/2025. 11/26/2025, 12/03/2025, 12/05/2025. There was one undated pre dialysis document with no post dialysis documented. Review of nursing progress notes from electronic medical record dated 11/12/2025 to 12/09/2025 did not have documented evidence of documented post-dialysis vital signs, weights, or evaluation of the dialysis access site 11/12/2025, 11/14/2025, 11/17/2025, 11/21/2025, 11/26/2025, 12/01/2025, 12/03/2025, or 12/05/2025. During an interview on 12/09/2024 at 2:14 PM, Licensed Practical Nurse #11 stated when residents leave and return from dialysis, vital signs, were taken and documented. They were unsure how to look up previous documentation history of vital signs taken. During an interview on 12/09/2024 at 2:15 PM, Licensed Practical Nurse #10 stated they were unsure how to look up previous documentation history of vital signs taken. During an observation and interview on 12/09/2025 at 2:20 PM, Resident #14 was sitting in their bed in their room. They stated they go to dialysis Monday, Wednesday, and Friday. They stated they take their dialysis book in their wheelchair bag when they go. During an interview on 12/09/2025 at 2:35 PM, Director of Nursing #1 stated the expectation was vital signs were to be documented in the electronic medical chart prior to residents leaving and returning from dialysis, as well as a report in the dialysis notebook upon return from the dialysis center. They stated the nurse on the unit was responsible to call the dialysis center to confirm treatment and tolerance if no documentation was received from dialysis center upon the resident's return. While surveyor was present, Director of Nursing #1 reviewed limited electronic medical records for 12/03/2025 and 12/05/2025 and could not locate documented vital signs upon return from dialysis for Resident #14. 10 New York Codes, Rules, and Regulations 415.12(k)

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	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review conducted during a survey, the facility failed to ensure that its medication error rate did not exceed five (5) percent for two (2) (Resident #303 and Resident #352) of five (5) residents observed during a medication pass for a total of 28 observations. This resulted in a medication error rate of 10.71 percent. Findings Include:The facility's policy and procedure titled General Medication Administration last reviewed 05/2025, documented medications will be administered by a Licensed Practical Nurse or a Registered Nurse. All medications will be administered and documented using the Electronic Medical Record. Check all resident orders carefully before administering the medications. Keep the basic rules of safe administration in mind: right drug, right resident, right time, right dose, right route, review for allergies, and review expiration date of medication. Avoid distractions when administering medications. Carefully check the resident's identification band before administering any medication. Do not leave medications at the bedside. If medication is found at the bedside or elsewhere, notify the Unit Manager/Supervisor. The Unit Manager/Supervisor will complete the Medication Error Form and dispose of the medication. Document all medication and treatment administration in the electronic medical record at the time they are given. Narcotic medications are to be signed for in the control drug book at the time they are administered and document administration in the electronic medical record. Review electronic medical record and electronic treatment record to ensure all medications and treatments were given at the end of assigned shift. All medications are to be properly labeled. All labels are to be clean and clear. If there is a direction change, the medication nurse is to put a direction change refer to chart label next to the original label. Only a pharmacist can re-label the medication card. If there is any doubt about a medication, the nurse should not administer it but should contact the Medical Doctor/Nurse Practitioner for clarification/instruction. During an observation on 12/05/2025 at 8:55 AM, Licensed Practical Nurse #12 reviewed Resident #352's Medication Administration Record and stated Resident #352 was to receive MiraLAX 17 grams mixed with water. There was no ordered amount of water to mix MiraLAX 17 grams with. Licensed Practical Nurse did not check MiraLAX bottle to verify correct amount of water to mix with, they mixed MiraLAX in an undetermined amount of water in a stock medication cart plastic cup. Upon entering Resident #352's room, Licensed Practical Nurse #12 did not verify resident, explain medications they were administering, or introduce themselves prior to giving Resident #352 their medications. Medication tablets were administered and witnessed; resident was left unattended with a full cup of MiraLAX for consumption.During an observation on 12/05/2025 at 9:30 AM, Licensed Practical Nurse #13 reviewed Resident #303's Medication Administration Record, which documented the resident was to receive Buspirone five (5) milligrams three (3) times a day. Licensed Practical Nurse #13 removed medication blister pack and proceeded to place one (1) tablet in a medication cup. The blister pack instructions read Buspirone five (5) milligrams twice a day. The surveyor identified the discrepancy and made Licensed Practical Nurse #13 aware. Licensed Practical Nurse #13 stated they had been giving Resident #303 this medication daily and would proceed to administer. The surveyor prompted Licensed Practical Nurse #13 to verify the order. They then called for Licensed Practical Nurse # 8 to get clarification of the order. Licensed Practical Nurse #8 clarified the new order of Buspirone five (5) milligrams was changed to three (3) times a day on 11/25/2025. The new blister pack with the correct order was found in the overflow drawer and the old blister pack was placed in the discontinued pile.During an interview on 12/05/2025 at 9:20 AM, Licensed Practical Nurse #12 stated they were a float nurse and they were not on their typical floor. They stated they were familiar with the residents and did not feel they needed to verify the resident prior to administering their medication. During an interview on 12/05/2025 at 9:50 AM, Licensed Practical Nurse #13 stated the process to follow if there was an order discrepancy for medication was to notify the unit manager or supervisor and receive clarification of order prior to administering medication. They stated they were familiar with Resident #303, so they felt comfortable administering (continued on next page)

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	335184	A. Building B. Wing	12/15/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their medication. During an interview on 12/10/2025 at 11:00 AM, Director of Nursing #1 stated all nursing staff who administer medications were assigned a preceptor during orientation. They stated staff received training on medication administration and were observed passing medications prior to being signed off to pass medications independently. All nursing staff followed the facility policy of safe administration: right drug, right resident, right time, right dose, right route, review for allergies, and review expiration date of medication. In addition, nursing staff were to avoid distractions when administering medications and carefully check the resident's identification band before administering any medication. 10 New York Codes, Rules, and Regulations 415.12 (m)(1)

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	335184	A. Building B. Wing	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and interviews conducted during the survey, the facility failed to provide a safe, functional, sanitary, and comfortable environment on three (3) of five (5) resident units. Specifically, strong urine odors were detected in several areas throughout the facility. Findings include: During observations on 12/03/2025 from 10:11 AM through 3:00 PM, on 12/04/2025 from 8:31 AM through 9:16 AM, on 12/05/2025 from 8:33 AM through 1:30 PM, on 12/08/2025 from 9:41 AM to 10:34 AM, and again on 12/10/2025 at 10:53 AM, strong urine odors were detected in rooms #555, 566 (two (2) observations), and 671 and in the north elevator lobby area on the third floor. During an interview on 12/09/2025 at 3:01 PM, Director of Environmental Services #1 stated that they would contact the nursing department to help investigate the odors. 10 New York Codes, Rules, and Regulations 483.90(i)

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	335184	A. Building B. Wing	12/15/2025

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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. Based on observation, record review, and interviews conducted during the survey, the facility failed to ensure a resident was assessed by the interdisciplinary team to determine a resident's ability to safely administer their own medications, if clinically appropriate, for one (1) of one (1) resident reviewed (Resident #314). Specifically, Resident #314 was observed on 12/03/2025 and 12/05/2025 with a bottle of unprescribed Clinical Treat Anti-Fungal Powder (treats fungal or yeast infections of the skin) NDC #5332916979 sitting on their bedside table in their room. There was no documented evidence of an assessment in the medical record and/or a physician order for the resident to self-administer the medication. The finding is:The facility's Policy and Procedure titled Self-Administration of Medications revised 08/2020, documented in order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team (or equivalent) has determined that the practice would be safe for the resident and other residents of the facility, and there is a prescriber's order to self-administer. For those residents who self-administer, the interdisciplinary team verifies the resident's ability to self-administer medications by means of a skill assessment conducted monthly or when there is a significant change in condition. The facility utilizes the resident's existing medication packages and has the resident complete all steps except for the actual removal of the medication from the package. The results of the interdisciplinary team assessment of resident skills and of the determination regarding bedside storage are recorded in the resident's medical record on the care plan. For each medication authorized for self-administration, the label contains a notation that it may be self-administered.Resident #314 was admitted to the facility with diagnoses of need for assistance with personal care; spinal stenosis site unspecified (occurs when the spaces in the spine narrow, putting pressure on the spinal cord and surrounding nerve roots) and depression unspecified (a common but serious mood disorder causing persistent sadness and loss of interest in activities, significantly impairing daily life). The Minimum Data Set (a resident assessment tool) dated 11/06/2025 documented the resident's cognition was moderately impaired, they were able to be understood and understand others.During an observation on 12/03/2025 at 2:49 PM, Resident #314 was sitting up in bed and next to the bed was resident's overbed table that contained one (1) bottle of Clinical Treat Anti-Fungal Powder. Resident #314 stated the nurse gave them the powder to put on as needed underneath breasts. During an observation on 12/09/2025 at 10:50 AM, Resident #314 was observed sitting up in bed, next to bed was resident's overbed table that still contained one (1) bottle of Clinical Treat Anti-Fungal Powder.During an interview on 12/09/2025 at 10:51 AM, Resident #314 stated they apply powder to a rash as needed underneath breasts.Review of the Comprehensive Care Plan for Resident #314 dated 10/01/2025 did not have documented evidence of a care plan for self-medication administration.The Medication Administration Reports dated October, November and December 2025 had no documented evidence of an order to administer Clinical Treat Anti-Fungal Powder to Resident #314.The weekly skin tracker sheet dated 10/28/2025 and 10/29/2025, documented an area of concern with redness to left chest. There were no corresponding nurse progress notes.During an interview on 12/09/2025 at 11:00AM, Licensed Practical Nurse #10 stated they had no residents that self-administer medications.During an interview on 12/10/2025 at 11:00 AM, Director of Nursing #1 stated they had no residents that self-administer medication. They stated that if a resident wished to self-medicate, the interdisciplinary team would conduct an assessment, followed by a physician order and the care plan would be updated. 10 New York Codes, Rules and Regulations 415.3(f)(1)(vi)

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	335184	A. Building B. Wing	12/15/2025

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observations, record review, and interviews during the recertification survey, the facility failed to ensure resident's right to make choices about aspects of his or her life in the facility that are significant for one (1) (Resident #211) of one (1) resident reviewed. Specifically, Resident #211 was not provided with food items recommended by the nutritionist's meal plan and resident's preferences, requiring the resident to purchase recommended items from an outside source. Findings include: The undated facility policy, Resident Orientation Handbook, documented residents have the right to be offered choices and allowed to make decisions and to receive services with reasonable accommodations for individual needs and preferences. Resident #211 was admitted to the facility with diagnoses that included Hodgkin lymphoma (cancer of the lymphatic system), pain, and anemia. The Minimum Data Set (a resident assessment tool) dated 09/24/2025 documented the resident was cognitively intact, could be understood and understands others. The Comprehensive Care Plan revised 11/04/2025 documented nutrition problem related to Hodgkin lymphoma, anemia, and edema. Problem goals were the resident tolerated least restrictive diet, weight stability, and skin showed improvement. Interventions included diet and fluids per provider order, active liquid protein, oral nutrition supplements and fortified foods with nourishment, and identified and honored preferences. The 11/04/2025 nutrition assessment, Registered Dietician #2 documented resident #211 received ensure plus and coffee for breakfast; ensure plus, orange wedges and two (2) sandwiches for lunch; and ensure plus, orange wedges, and two (2) sandwiches for dinner. The resident preferred only to have sandwiches, oral nutrition supplements, and oranges with meals. The 11/21/2025 nutritionist note, Registered Dietician #2 documented the resident's son brought food in for them and Registered Dietician #2 had brought up sandwiches from the kitchen to promote adequate intake. During an interview on 12/03/2025 at 10:31 AM, Resident #211 stated they provided the facility with foods that they could eat, and the facility did not provide them. They bought their own food and kept it in a refrigerator in their room. Certified Nurse Aides brought them sandwiches they could eat when they were not provided with meals. During an interview and observation on 12/09/2025 at 9:39 AM, Resident #211 stated they ordered out every two weeks for sandwiches that were not provided by the facility. Meals that were brought up usually had one sandwich. Certified Nurse Aide #8 noticed resident was provided nothing for dinner and went down to the kitchen and made them a sandwich. Resident #211 opened the refrigerator in their room that had wrapped sandwiches, bottled water and Ensure ordered by the resident from an outside source. During an interview on 12/09/2025 at 8:58 AM, Certified Nurse Aide #5 stated there were times that there were missing items or not enough food for residents. Resident #211 complained that they were not provided sandwiches or not provided two (2) sandwiches. They had been told by dietary that there were no more sandwiches and to find something else to offer the resident. The resident had food in their room that they purchased themselves. During an interview on 12/09/2025 at 9:00 AM, Registered Nurse #4 stated they had residents that complained that there was not enough food. When food was not brought up on the resident tray, they would call down to dietary to have it brought up. Resident #211 complained that they were not getting their preferences on their tray. They stated Resident #211 did have a refrigerator in their room and had Ensure and snacks. During an interview on 12/09/2025 at 9:27 AM, Dietary Aide #2 stated there were not enough sandwiches at times. They called down to the kitchen to have a sandwich brought to the unit when there was not enough. When dietary had none of an item, supervisors told them to try to offer something else. They attempted to provide the resident's preference that was part of their meal plan. During an interview on 12/09/2025 at 10:47 AM, Certified Nurse Aide #8 stated Resident #211 was not provided their preference for meals often. They further stated when Resident #211 was not provided with anything for a meal; and they went into the kitchen and made a sandwich as there was no food in the kitchenettes.During an interview on 12/12/2025 at (continued on next page)

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	335184	A. Building B. Wing	12/15/2025

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:26 AM, Administrator #2 stated auditing was an ongoing process which included talking with residents. There were no specific topics offered by the Ombudsman during the last survey. 10 New York Codes, Rules and Regulations 415.5(b)(3)

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	335184	A. Building B. Wing	12/15/2025

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review conducted during the survey, the facility failed to ensure each resident's right to file a grievance and/or prompt efforts were made to resolve grievance for one (1) (Resident #380) of three (3) residents reviewed for grievances. Specifically, there was no documented evidence that a grievance was filed, an investigation was conducted, and/or a grievance was resolved when Resident #380's responsible party reported to staff the resident was missing a new pair of sneakers and multiple clothing items. The finding is:The policy titled Lost or Missing Items, review/revision dated 05/16/2025, documented the facility will review and investigate all lost and missing items and unauthorized use or removal of resident's property. Upon noting a loss, the staff receiving the complaint or designee will initiate the missing items report form and include all known information about the item. Staff will follow the checklist on the missing item form to search for the item. If the item is not found, staff will notate that on the form, and the form will be forwarded to the Chief Experience Officer. The Chief Experience Officer will review the Lost/Missing Items. The family or resident will be provided with the results of the investigation and assisted with any further steps toward a resolution.Resident's Free from Accident, Refer to the citation text under F804.The facility failed to ensure the residents' environment remained free of accident hazards for 1 of 6 residents reviewed. Resident #380 was admitted to the facility with diagnoses including Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills), anxiety, and hypertension (high blood pressure). The Minimum Data Set (a resident assessment tool) dated 06/19/2025 documented the resident had moderate cognitive impairment. During a telephone interview on 12/04/2025 at 11:25 AM, Resident #380's responsible party stated they had reported to Social Worker #3 that Resident #380 was missing 3 bags of clothing, 2 coats, and a new pair of sneakers a couple of months ago. Additionally, the responsible party stated they had not received a resolution to the missing items from the facility. During an interview on 12/08/2025 at 9:51 AM, Social Worker #3 stated Resident #380's responsible party reported missing clothing items to them a few months ago. Social Worker #3 stated they completed a missing item report and forwarded the report to the Director of Social Work or the Chief Experience Officer. During an interview on 12/08/2025 at 9:58 AM, Chief Experience Officer #1 stated whoever gets a report of missing items completes the missing item form and forwards the completed form to them. The Chief Experience Officer and/or Administrator complete an investigation of the missing item/items and offer a resolution to the resident and/or responsible party. Additionally, Chief Experience Officer #1 stated there was no record of a missing items report for Resident #380. 10 New York Codes, Rules and Regulations 415.3 (d)(1)(ii)

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	335184	A. Building B. Wing	12/15/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observations, record reviews, and interviews, the facility failed to ensure that residents received treatment and care in accordance with professional standards for one (1) (Resident #1) of one (1) resident reviewed. Specifically, Resident #1 was observed to have an old bandage on their left forearm with no documentation in the resident's medical records.Findings include:Resident #1 was admitted to the facility with diagnoses of Parkinson's disease (a progressive brain disorder affecting movement), dysphagia (difficulty swallowing food or liquids), and dementia (a group of symptoms affecting memory, thinking, and social abilities). The Minimum Data Set (a resident assessment tool) dated 10/10/2025 documented the resident was understood, could understand others and was cognitively intact.During an observation on 12/04/2025 at 9:54 AM, a bandage was noted on Resident #1's left forearm dated 12/01/2025. Resident #1 stated they did not know what was under the bandage but that it might be a skin tear.During an observation on 12/05/2025 at 11:47 AM, the bandage was noted to still be in place with the date of 12/01/2025.There was no documented evidence of orders for a treatment to the left arm.There was no documented evidence of entries on either the Medication Administration Record or Treatment Administration Record for December 2025 for a bandage or dressing change on the left forearm.There were no progress notes in November 2025 or December 2025 documenting the presence of any skin issue on the left forearm.There was no documented evidence of recent Incident and Accident forms that could have indicated the source of any skin issues on the left forearm.In a Nurses Note dated 12/05/2025, Registered Nurse #2 documented the bandage was removed and a dry, healed area was noted.During an interview on 12/05/2025 at 10:27 AM, Licensed Practical Nurse #1 stated they changed the bandages on 12/01/2025 and had not worked between then and 12/05/2025. They did not recall what was under the bandage, but thought it was a skin tear. They stated there had been a bandage on it prior, so they assumed the issue had been reported. They did not recall if there was an order to change the bandage and expressed surprise when the Treatment Administration Record was reviewed and there was no order.During an interview on 12/08/2025 at 9:15 AM, Registered Nurse #1 stated they would expect an order for any dressing that was on a resident. They stated that any injury should be accompanied by an Incident and Accident report.During an interview on 12/09/2025 at 10:40 AM, Registered Nurse #2 stated there was nothing under the bandage that was removed on 12/05/2025. They stated when a new skin issue is found, they are notified, and they were not notified for any new skin issues for Resident #1. They stated there should be orders for dressings and bandages.During an interview on 12/09/2025 at 10:53 AM, Director of Nursing #1 stated skin issues should be reported, and dressings required an order and entry onto the Treatment Administration Record.10 New York Codes, Rules, and Regulations 415.12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	12/15/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews conducted during the survey, the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' physician orders for one (1) (Resident #143) of four (4) residents reviewed. Specifically, Resident #143 was observed with oxygen tubing dated [DATE] and not changed as ordered. The finding is: The facility policy Oxygen Therapy Policy and Procedure revised [DATE] documented nasal cannula or OxyMask were labeled and dated when set up. Nasal cannulas or OxyMasks were changed every two (2) weeks or as needed if visibly soiled. When the nasal cannula or OxyMask was changed it was labeled, dated, and documented in the administration record. Resident #143 was admitted to the facility with diagnoses including acute and chronic respiratory failure with hypoxia (tissues do not get enough oxygen to function properly), pneumonia, and chronic obstructive pulmonary disease (progressive lung disease making breathing difficult). The Minimum Data Set (a resident assessment tool) dated [DATE] documented the resident had intact cognition, was independent for all activities of daily living, ambulated independently, had pulmonary diagnosis, and did not reject care. The Comprehensive Care Plan documented Resident #143 initiated [DATE] and last updated [DATE], documented the resident had compromised respiratory status. Interventions included monitoring activity tolerance, oxygen per physician order, monitor oxygen saturation, and encourage nicotine dependent residents to eliminate smoking. The undated resident care instructions documented use of oxygen therapy. The [DATE] order by Physician #1 documented oxygen therapy at six (6) liters nasal cannula check every day every shift. Clean equipment and change tubing monthly on the 1st and 15th during the day shift. During an observation and interview on [DATE] at 9:51 AM, Resident #143 was observed in their room wearing oxygen at six (6) liters via nasal cannula. The tubing was dated [DATE] with initials LEC. Resident #143 stated it had been several weeks since the tubing was changed, and it does not get changed often. During an observation and interview on [DATE] at 2:07 PM, Resident #143 was observed in their room wearing oxygen at six (6) liters via nasal cannula. The tubing was dated [DATE] with initials LEC. The resident stated the nurse changed the tubing earlier in the day and disposed of the old tubing in their garbage. The treatment administration record for December documented time had expired for the oxygen tubing change on [DATE]. This was documented by Licensed Practical Nurse #7. Licensed Practical Nurse #7 documented they changed the oxygen tubing on [DATE] and [DATE]. During an interview on [DATE] at 12:25 PM, Certified Nurse Aide #3 stated there were several residents on the unit that required oxygen. Nurses were responsible for monitoring oxygen therapy. During an interview on [DATE], Licensed Practical Nurse #4 stated nurses were responsible for managing oxygen therapy for residents that required oxygen. They stated they monitored oxygen levels, made sure oxygen tanks were working properly, made sure residents were not smoking when oxygen was in use, and changing tubing according to the physician order. When tubing was changed, it was dated and documented on the treatment administration record. During an interview on [DATE], Licensed Practical Nurse #7 stated they had several residents that required oxygen on their unit. Medications and treatments were not signed as completed until after completion because they could be interrupted, the resident might refuse, or the resident might not be available. They only signed treatment as completed when it was finished. They further stated that certified nurse aides were responsible for making sure portable oxygen tanks were full, and licensed practical nurses were responsible for making sure residents were properly hooked up to the concentrator and changed tubing according to the physician's order. They stated they worked on [DATE] and did not change the tubing for Resident #143 because they were working a double and were busy in the morning. They did not sign the treatment was completed and planned on changing the tubing in the evening but forgot. On [DATE], they remembered Resident #143 needed their oxygen (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	12/15/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tubing changed and completed the task. They further stated they dated the tubing [DATE] and were not sure why they labeled the tubing with a date that did not correlate with the task. They stated they should not have labeled the tubing for a date the tubing was not changed because it was falsifying records. They should have changed the oxygen tubing according to the physician's order as it was an infection control concern. During an interview on [DATE] at 8:54 AM, Registered Nurse Supervisor #5 stated portable oxygen tanks were filled by certified nurse aides at the end of their shift. Nurses were responsible for monitoring oxygen use, changing tubing, and changing the humidification bubbler as ordered. Oxygen tubing was changed weekly and required a physician's order. When oxygen tubing was changed, it was documented on the treatment administration record. They expected treatments to be signed after completion because you could get distracted or forget to complete the task. Resident #143 had bad chronic obstructive pulmonary disease, poor lung function, and wore oxygen. They stated on [DATE], the resident should not have had tubing dated [DATE]. They were not sure why the tubing was not changed but it should have been. Not changing the tubing put the resident at higher risk for infection. They were not sure why the nurse dated the tubing changed [DATE] for [DATE] but they should not have. The date on treatment should correlate to when the treatment was completed. Incorrectly signing treatment was also a safety concern.10 New York Codes, Rules and Regulations 415.12(k)(6)