STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335077	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwoods Rehab and Nursing Center at Moravia	7 Keeler Avenue Moravia, NY 13118

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, record review, and interviews during the recertification and abbreviated (IQIES 676829) surveys conducted 9/22/2025-9/25/2025, the facility did not ensure allegations of abuse, neglect, or mistreatment were thoroughly investigated for two (2) of four (4) residents (Residents #32 and #45) reviewed. Specifically, the facility did not complete a thorough investigation after neglect related to medication errors and did not report the incidents to the New York State Department of Health as required. Findings include: The facility policy Accident and Incident Investigation, revised 4/3/2024, documented the reporting of incidents, accidents and abuse to state and federal agencies needed to follow agency guidelines. A completed incident and accident report included the date, time and location of the accident/event or abuse allegation occurred, nature of illness or injury, circumstances surrounding the occurrence, names of witnesses and the account of the occurrence, the effected person's account of the occurrence, date and time of physician/responsible party notification, condition of the resident with vital signs included, disposition of the resident, corrective action taken, documentation in the medical record completed, care plan updated if indicated, follow up information, and any other pertinent data as required.The facility policy Medication Error Management, revised 11/5/2019, documented it was the responsibility of every employee to report any known, suspected or potential medication error. Medication errors were classified by their severity. Each medication error or potential error identified was investigated by nursing administration and current processes were assessed for areas of improvement. The medical director in conjunction with the resident's attending physician determined if and to what extent there was permanent resident harm. 1) Resident #32 had diagnoses including generalized anxiety disorder, dementia with behavioral disturbance, and major depressive disorder. The 4/22/2024 Minimum Data Set assessment documented the resident had severely impaired cognition; moderate depression; had inattention, disorganized thinking, and altered level of consciousness continuously; had verbal behavioral symptoms directed toward others; other behavioral symptoms not directed toward others; wandered daily; and received antianxiety and antidepressant medications daily. The Comprehensive Care Plan initiated 4/23/2021 documented the resident used psychotropic medications related to depression and anxiety. Interventions included administer psychotropic medications as ordered by physician. The 10/21/2024 physician order documented clonazepam oral tablet, 0. 5 milligrams, give one tablet by mouth in the afternoon for anxiety. The order was to start on 11/2/2024. The 11/2024 Medication Administration Record documented clonazepam oral tablet 0.5 milligrams, give one tablet by mouth in the afternoon at 2:00 PM for anxiety. On 11/17/2024 Registered Nurse #16 signed the 0.5 milligrams of clonazepam was administered. Resident #32's controlled drug record for clonazepam 0.5 milligrams documented one tablet was removed on 11/16 at 2:00 PM (illegible signature) and there were 16 tablets remaining. There was no documented evidence clonazepam 0.5 milligrams was signed out on 11/17/2024. The pharmacy blister pack for Resident #32's clonazepam 0.5 milligrams documented there were 16 tablets remaining after the removal off one tablet on 11/16/2024. There were no Registered Nurse #16 progress notes documenting the reason clonazepam was not administered on 11/17/2024 after being signed for on the Medication Administration Record. A 11/26/2024 narrative completed by former Director of Nursing #6 documented on 11/18/2024 licensed practical nurse staff (unnamed) reported to them Registered Nurse #16 signed for the administration of a narcotic medication, but the medication was not signed out of the narcotic book nor was it removed from the blister pack. Director of Nursing #6 spoke to Registered Nurse #16 who stated if it was signed for, they gave it. All other narcotic medications on that side were correct in count. Registered Nurse #16 was terminated from employment on 11/22/2024. There was no documented evidence the medication omission was reported to the New York State Department of Health. 2) Resident #45 had diagnoses including osteomyelitis (bone infection) of the left hand. The 10/16/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition.The 11/1/2024 at 12:57 AM Licensed Practical Nurse #22 progress note documented the resident returned from a hospital stay due to an infection to the left hand middle finger. The resident had a peripherally inserted central catheter (intravenous access device) and was receiving antibiotics at the hospital. The antibiotic would be administered next shift by the registered nurse. The 11/6/2024 Nurse Practitioner #21 progress note documented the resident had a left hand middle digit amputation and infection and was receiving antibiotics via a peripherally inserted central catheter.The November 2024 Medication Administration Record documented ceftriaxone (antibiotic) reconstituted 1 gram intravenously every 24 hours for infection until 12/13/2024 with a start date of

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interviews during the recertification survey and abbreviated (NY00361275) surveys the facility did not ensure residents were free of significant medications errors for two (2) of two (2) residents (Residents #32 and #45) reviewed. Specifically, Registered Nurse #16 falsely documented administering clonazepam (antianxiety medication) to Resident #32 and failed to administer multiple doses of an intravenous antibiotic to Resident #45.Findings include: The facility policy Medication Error Management, revised 5/2019, documented it is the responsibility of every employee to report any known, suspected or potential medication error. Each medication error or potential error identified will be investigated by nursing administration and current processes will be assessed for areas of improvement. 1) Resident #32 had diagnoses including generalized anxiety disorder, dementia with behavioral disturbance, and major depressive disorder. The 4/22/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, behavioral symptoms directed toward others and received antianxiety and antidepressant medications daily. The Comprehensive Care Plan initiated 4/23/2021 documented the resident used psychotropic medications related to depression and anxiety. Interventions included administer psychotropic medications as ordered. The 11/02/2024 physician order documented clonazepam 0.5 milligrams one tablet by mouth every afternoon for anxiety. The 11/2024 Medication Administration Record documented on 11/17/2024 at 2:00 PM Registered Nurse #16 administered clonazepam 0.5 milligrams one tablet to Resident #32. There was no documented evidence on the controlled substance drug log Registered Nurse #16 removed the clonazepam from the blister pack and administered the medication to the resident. The clonazepam drug log remained at a count of 16 tablets in the blister pack, which was the same amount remaining after the medication was administered on 11/16/2024 at 2:00 PM. 2) Resident #45 had diagnoses including osteomyelitis of the left hand (bone infection) and partial amputation of the left middle finger. The 10/16/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition. The 11/01/2024 and 11/05/2024 physician order documented ceftriaxone (antibiotic) one gram intravenously every 24 hours.The November 2024 Medication Administration Record documented ceftriaxone one gram intravenously every 24 hours for infection. There was no documented evidence the intravenous ceftriaxone was administered on 11/1/2024, 11/2/2024, 11/4/2024, 11/8/2024, 11/11/2024, and 11/16/2024.There was no documented evidence in the medical record related to the ceftriaxone omissions. The 11/26/2024 investigative narrative completed by former Director of Nursing #6 documented a licensed practical nurse (unnamed) reported intravenous medications for Resident #45 had not been administered as ordered. Registered Nurse #16 was responsible for administering the medication on the days they were scheduled to work. Registered Nurse #16 told them I do my job, and I do all that I am supposed to do. I likely hung it and forgot to document in the medication administration record. Registered Nurse #16 was unable to explain why there were an extra number of intravenous antibiotic bags in the medication room and responded, I don't know why that is there, maybe the pharmacy sent extra. The number of intravenous antibiotics in the med room coincided with the number of days the antibiotic was unsigned for. The 11/26/2024 disciplinary and termination write up for Registered Nurse #16 by former Director of Nursing #6 documented on 11/18/2024 it was reported the registered nurse signed for a narcotic medication stating it was administered to Resident #32 per the electronic medical record; however, the medication was not signed out of the narcotic book nor was it removed from the medication blister pack. They were also made aware that Registered Nurse #16 had not administered intravenous antibiotic medication as ordered for multiple days they worked. During an interview on 9/24/2025 at 1:21 PM, Licensed Practical Nurse #11 stated the registered nurses administered all intravenous antibiotics. If they noticed an intravenous antibiotic was not signed for, they should tell the supervisor and document in a progress note. During an interview on 9/24/2025 at 1:43 PM, Director of Nursing #2 stated only registered nurses administered intravenous antibiotics. If medications were not given the provider should be notified and then documented in a progress note. If it was noticed that a nurse did not administer medications to one resident, they looked at all medication administration records for all residents and medication blister packs to ensure medications were given to other residents. Failure to administer medications required an investigation to rule out neglect or abuse. They were not employed by the facility at the time of the incidents with Resident #32 or Resident #45. During an interview on 9/24/2025 at 2:20 PM, Physician #18 stated if intravenous antibiotics were not administered, they should be called. A provider should always be notified. They did not recall Resident #32 but recalled Resident #45. They expected