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	06/13/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48675 49831 Based on observation, record review, and interview during the recertification survey conducted 6/10/2024 through 6/13/2024, the facility did not ensure the development and implementation of a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 3 of 12 residents (Residents # 6, #9 and # 13) reviewed. Specifically, Resident #6 was not care planned for contractures; and Resident # 9 and Resident #13 were not cared planned for anticoagulant (drug used to prevent blood clots from forming or traveling to vital organs) therapy. Findings Include: The facility policy Comprehensive Care Plan, revised 6/25/2020 documented the facility's care planning/interdisciplinary team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain, and that each resident's comprehensive care plan has been designed to Incorporate identified problem areas, and enhance the optimal functioning of the resident by focusing on a rehabilitative program. The facility policy Resident Assessment Instrument documented that a comprehensive assessment of a resident's needs shall be made within fourteen (14) days of the resident's admission. The Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and reviews. The Interdisciplinary Assessment Team must use the Minimum Data Set (MDS) form currently mandated by Federal and State regulations to conduct the resident assessment. The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity. Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1) Resident #6 was admitted to the facility with diagnoses of flaccid hemiplegia (severe or complete loss of functioning on one side of the body) and Type 2 diabetes without complications. The Minimum Data Set, dated dated dated [DATE] documented the resident was cognitively intact, required extensive assistance of 2 for bed mobility; was a full Hoyer lift, had an activities of daily living self-care performance deficit related to bilateral amputation of their legs, left hemiparesis (one-sided muscle weakness), required substantial/maximal assistance for most activities of daily living, received no restorative program services, and did not reject care. The 3/16/2021 care plan documented the resident had limited physical mobility and impairment of their left hand related to cerebral vascular accident (stroke). The comprehensive care plan initiated 2/12/2024 documented Resident #6 had an activities of daily living self-care performance deficit related to bilateral left hemiparesis. The care plan did not include interventions to address the resident's left hemiparesis or contractures in their left hand. The 2/12/2024 resident care instructions did not include instructions for passive range of motion, left palm guard or hand splint. The 5/29/2024 at 19:36 PM Physician progress note documented Resident #6 had a past medical history of cerebral vascular accident (a stroke) with left sided hemiparesis (weakness). Resident #6 was observed: -On 6/11/2024 at 1:12 PM, in their room, sitting up in their wheelchair. The resident's left hand was observed to be contracted with their fingers bent at the first knuckle with a bear claw appearance. The resident attempted to open their left hand using their right hand and was not able to. There were no palm guards or hand splint in the resident's left hand. During an observation and interview on 6/11/2024 at 2:58 PM, there were a stack of round, colorful plastic balls on the resident's nightstand. The Resident stated the staff would hand the balls to them and tell them to hold them to keep their left hand open. They would not place a palm guard or splint in their left hand, and they did not attend therapy. The Resident stated they thought they needed therapy. During an observation on 06/13/2024 at 10:18 AM, the resident was lying in the bed watching television and did not have a left palm guard or hand splint applied to their left hand. The 3/14/2021 - 3/19/2021 Occupational Therapy Evaluation documented the resident required skilled occupational therapy services due to complicated medical history, associated musculoskeletal conditions and impairments to multiple areas of the body including left upper extremities. During an interview on 6/12/2024 at 11:13 AM, Certified Nurse Aide #16 stated Resident #6 had a stroke on the left side. As a result, they stated the resident's left hand did not work and the resident's left hand was contracted. Certified Nurse Aide #16 stated the resident's care plan should include information about their contracture, and the Kardex should have indicated a rolled towel or palm guard for the resident; they couldn't recall this information being included on Kardex for the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/2024 at 10:39 AM, Licensed Practical Nurse #9 stated registered nurses were responsible for development of the care plan when residents were admitted . They stated Resident #6 was dependent on the staff for assistance with most activities of daily living and had a stroke that resulted in left sided weakness. They stated to their knowledge the resident had no contractures and therapy would work with the resident when their mobility decreased. Licensed Practical Nurse #9 stated Resident #6 was at their baseline for restorative therapy. During an interview on 6/13/2024 at10:48 AM, Registered Nurse #8 stated they and registered nurse #5 were responsible for the development of the nursing section of the care plan. They stated that other departments were responsible for creating their section of the care plan; Initial care plans were completed within 24 hours of the resident's admission and modified as needed. They stated if a resident had a contracture, the resident should be care planned for the contracture, and Resident #6 had a contracture of their left hand. Licensed Practical Nurse #8 stated it was important that care planning and interventions be put in place to ensure residents received the care needed. When care planning and interventions are not in place, the staff would not know how to care for residents and residents would not receive the care needed. During an interview on 6/13/24 at 11:00 AM, with Physical Therapist # 14, they stated regarding care planning, they would assess the resident's level of mobility for bed mobility, transfers and ambulation and advise nursing accordingly upon admission and when the resident had a decline in functioning. If a newly admitted resident had a prior history of stroke and left or right sided weakness, they would be care planned for contracture management inclusive of stretching, range of motion exercises and hand splints. Physical Therapist #14 stated they work with a resident's lower body functioning and their hand contracture would be managed by the Occupational Therapist. During an interview on 6/13/2024 at 11:09 AM with Occupational Therapist #15, they stated with new admissions, they would complete an evaluation to determine the level of care needed by a resident and develop a care plan for the needed services. Occupational Therapist #15 stated they educated certified nursing assistants to conduct passive range of motion and stretching on Resident #6, had administered competencies to them and the expectation for Resident #6 was for it to be completed. The certified nursing aides would know how to care for the resident as the information on their care plan carried over to the resident care instructions. Occupational Therapist #15 stated Resident #6 had a contracture of their left hand, and it was not on their care plan. They stated it was their error that it was omitted, and if Resident #6 was not care planned for contracture management of the left hand it would indicate that resident was not receiving the passive range of motion needed. They stated the risk of the resident not being care planned for their left handed contracture could result in a decline in function of their hand, could have developed skin breakdown, had a decline in range of motion, and developed pain associated with the arm/hand being contracted. On 6/13/2024 at 11:46 AM, there were no nurse aide competencies for passive range of motion, hand splints or palm guard application provided as requested. The Administrator stated there were none to provide. 2) Resident #9 had diagnoses including chronic obstructive pulmonary disease (chronic lung disease that blocks airflow) and atrial fibrillation (irregular heartbeat). The 10/16/2023 Minimum Data Set assessment documented the resident had moderately impaired cognition and received an oral anticoagulant (blood thinner) daily. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/1/2022 physician order documented the resident was to receive apixaban (blood thinning medication) 2.5 milligram two times per day for atrial fibrillation with no end date. The comprehensive care plan revised on 5/16/2024 did not include interventions for anticoagulant therapy. During an interview on 6/13/2024 at 9:35 AM, Licensed Practical Nurse #12 stated they would look at a resident's care plan to know how to properly care for them. Care plans included specifics like activities of daily living and medications. They passed medications and completed treatments but did not touch care plans. They were unsure how often care plans were reviewed and updated but if they noticed an issue or needed a care plan updated, they would notify the assistant director of nursing, and they would make the changes. They stated if Resident #9 was on an anticoagulant they thought it should have been in their care plan so staff would know what to monitor for. During an interview on 9/13/2024 at 10:13 AM, the Assistant Director of Nursing stated care plans were initiated upon admission and were reviewed/updated quarterly and as needed. The licensed practical nurses did not initiate or update care plans, they would notify them, and they would make the necessary changes. The care instructions were generated from the care plan and would automatically update when changes were made. Care plans were resident specific and would include certain medications like blood pressure medication or anticoagulant medication so staff would know what to monitor for. Resident #9 was on a daily anticoagulant and should have had interventions to monitor for bruising or blood in the urine or stool. If Resident #9 had a fall, it could put them at risk if staff did not know to monitor for bleeding. They stated it was important to keep Resident #9's care plan updated so they could safely care for them. 3) Resident #13 was admitted to the facility with a diagnosis of chronic atrial fibrillation (irregular heartbeat). The 4/13/2024 Minimum Data Set assessment documented the resident was rarely understood and received an oral anticoagulant (a medication that thins the blood) daily. The 2/14/2024 physician order documented Apixaban 5mg (anticoagulant) twice a day for atrial fibrillation with no end date. The comprehensive care plan did not document anticoagulation therapy. The 6/13/2024 resident care instructions did not include monitoring for signs of abnormal bleeding. During an interview on 6/13/2024 at 10:10AM, the Assistant Director of Nursing stated care plans were created on admission, reviewed every 90 days, and modified in between as needed. If a resident was on an anticoagulant there should be a care plan with interventions to monitor for signs of bleeding and those interventions would be carried over to the resident care instructions. They stated it was important to do this as abnormal bleeding would need immediate attention. Initially, they stated Resident #13 was not on an anticoagulant as it had been discontinued. After they checked the orders, they stated they were mistaken, and the resident was on an anticoagulant and should be care planned as such. 10NYCRR 415.11(c)(1) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50561

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	335077	A. Building B. Wing	06/13/2024

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48675 Based on observation, record review, and interviews during the recertification and abbreviated (NY00312820) surveys conducted 6/10/2024-6/13/2024, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for 1 of 4 residents (Resident #22) reviewed. Specifically, Resident #22 was not assisted with shaving unwanted facial hair. Findings include: The facility policy Activities of Daily Living initiated 1/23/2024 documented residents would be provided with care and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who were unable to carry out activities of daily living independently would receive services and appropriate support with elimination, dining, mobility, and hygiene (bathing, dressing, grooming, and oral care). If care or services was refused, the refusal and information would be documented in the resident's clinical record. Resident #22 had diagnoses including alcohol dependence with alcohol- induced persisting dementia, unspecified abnormalities of gait and mobility, and weakness. The 4/2/2024 Minimum Data Set assessment documented the resident was cognitively intact, required set-up or clean-up assistance with personal hygiene, and did not refuse care. The comprehensive care plan revised 1/18/2020 documented the resident had activities of daily living self-care performance deficit. Interventions included encourage the resident to participate to the fullest extent with each interaction, praise all efforts of self-care, was the resident's facial hair shaved, and the resident required set-up assistance with showers, bathing, and personal hygiene. The resident was observed during the following with thick, curly facial hair covering their entire chin, upper lip, and neck: - On 6/10/2024 at 11:52 AM lying in bed. The resident stated they would like their facial hair shaved or trimmed, that staff would not bring in a razor, and if they had a razor, they would do it themselves. - On 6/12/2024 at 10;01 AM lying in bed. They stated they wanted their facial hair shaved because it was making their face itch, staff did not bring in a razor and they did not offer to shave them. The certified nurse aide documentation report documented Resident #22 received set-up or clean-up assistance with personal hygiene during the day shift on 6/10/2024, 6/11/2024, and 6/12/2024. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/2024 at 9:24 AM, Certified Nurse Aide #13 stated they looked at a residents' care plan or care instructions daily to know how to properly care for them. Personal hygiene consisted of hair care, face washing, oral care, and shaving or trimming facial hair for both men and women. They were familiar with Resident #22, and they had provided care to them. If they documented they completed personal hygiene it meant they offered and completed the task. If a resident refused care they would document the refusal, notify the licensed practical nurse, and they would reapproach the resident. They stated it was normal for Resident #22 to refuse care, they thought they had offered to shave them, and they did not notify the nurse of any refusals. They stated they had not offered or thought to bring in a razor or set them up to shave. Resident #22 required set-up assistance; if they had known they wanted to shave they would have brought in the appropriate supplies. They stated it was important to ask Resident #22 if they wanted to shave because they had the right to choose and to maintain their dignity. During an interview on 6/13/2024 at 9:35AM, Licensed Practical Nurse #12 stated certified nurse aides were responsible for providing daily care and activities of daily living. Personal hygiene was offered and completed daily for every resident and consisted of bathing, shaving, grooming, and oral care. If a resident refused, the certified nurse aide would notify them, and they would reapproach the resident. If they continued to refuse, they would document the refusal in a progress note. They stated if a resident had a beard or facial hair, they would usually remind the certified nurse aide to shave them even if it was not their shower day. Resident #22 was very particular with their care, they liked to do things on their own, and they were not notified of any refusals. They stated they had noticed Resident #22's facial hair, had not asked the certified nurse aides to shave them, and they had not approached the resident or offered any assistance. They stated it was important to ask Resident #22 if they wanted to shave for their dignity and to make them feel good about their appearance. During an interview on 6/13/2024 at 10:27 AM, the Assistant Director of Nursing stated personal hygiene consisted of bathing, dressing, oral care, nail care, and shaving for both men and women. If the certified nurse aide documented personal hygiene was completed it meant it was offered and the task was fully completed. Shaving was on Resident #22's care instructions, so they expected it to be offered daily even if Resident #22 had a history of refusals. If any resident refused care, the staff would reapproach and then the nurse would write a progress note of what task was refused and why they refused it. They were not notified of any recent refusals for Resident #22 and there were no recent progress notes. They stated it was important to offer and allow Resident #22 to shave for their dignity and sense of wellbeing. 10NYCRR 415.12(a)(3)

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	335077	A. Building B. Wing	06/13/2024

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 48675 Based on observation and interviews during the recertification survey conducted 6/10/2024-6/13/2024, the facility did not post the following required information on a daily basis: the current resident census and the total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift, in a prominent place readily accessible to residents and visitors for 4 of 4 days reviewed. Specifically, the facility did not post the resident census and nurse staffing information daily, as required. Findings include: The facility did not have a policy on posting daily nurse staffing. The daily resident census and nurse staffing information was not observed in an area that was readily accessible to residents and visitors: - On 6/10/2024 at 9:30 AM. - On 6/11/2024 at 8:05 AM. - On 6/12/2024 at 9:29 AM. - On 6/13/2024 at 8:00 AM. During an interview on 6/13/2024 at 8:34 AM, Nurse Staff Scheduler/Charge Nurse #9 stated they were responsible for the nursing staff schedule. They were not aware daily staffing and census had to be posted in a public area or they would have posted it daily. During an interview on 6/13/2024 at 8:42 AM, the Director of Nursing stated they assisted with the nursing staff schedule. They kept a copy of the staff schedule, but it was not posted anywhere in the facility that was accessible to the public. They were not aware staffing and census had to be posted daily in an area visible to residents and visitors and they would start posting it immediately. 10 NYCRR 415.13

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 50561 Based on record review and interview during the recertification survey conducted from 6/10/2024-6/13/2/24, the facility did not maintain drugs and biologicals labeled in accordance with currently accepted professional standards, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 2 medication carts (Side 2) reviewed. Specifically, Side 2 medication cart had three medicated eye drops that were opened and not dated. Findings include: The undated facility policy, Medication Storage, documented that medications would be stored in a manner that maintained the integrity of the product, ensured the safety of the residents and was in accordance with Department of Health guidelines. During an observation on 6/11/2024 at 11:35 AM with Licensed Practical Nurse #12, Side 2 medication cart contained the following medications opened and undated: - erythromycin Ophthalmic Ointment 5 milligrams/gram (antibacterial) - Polyvinyl Alcohol Ophthalmic Solution 1.4% (lubricant) - Timolol Maleate Ophthalmic solution 0.25% for glaucoma (eye disease) During an interview on 6/11/2024 at 11:35AM, Licensed Practical Nurse #12 stated medications should be labeled with the date opened. If an opened medication was not dated, they would discard and order a replacement. Eye drops were usually good for 30 days once opened. If an expired medication was given it might not be at the appropriate dose and be less effective. During an interview on 6/13/2024 at 12:16PM with the Director of Nursing, stated when a medication was opened it should be dated with the open date or the date the medication would expire. Eye drops were good for 30 days from the open date unless otherwise specified. If there was no date on an opened medication, it should be discarded. That was important as expired medications could have less efficacy and cause adverse effects. 10NYCRR 415.18(d)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 34459 49831 Based on observation, interview and record review during the recertification and abbreviated (NY00312820) surveys conducted 6/10/2024 - 6/13/2024, the facility did not ensure each resident received food and drink that was palatable, attractive, and at a safe and appetizing temperature for 1 of 1 meal test trays reviewed (6/11/2024 lunch meal). Specifically, the lunch tray included foods that were not palatable or served at safe and appetizing temperatures. Findings include: The facility Policy and Procedure Food Temperatures policy, revised 6/27/2022, documented food stored hot would be kept at 135 degrees Fahrenheit or above. Food in refrigerators would be kept at 41 degrees Fahrenheit or below. Food would be served at palatable temperatures within those guidelines. Temperatures of food items would be checked prior to service to the residents and as frequently as necessary when being stored hot for service. During an interview on 6/10/2024 at 10:03 AM, Resident #3 stated the food served to residents did not have an appetizing taste. Hot foods served were not hot enough and the food got cold before they could eat it. During an observation on 6/11/2024 at 11:59 AM, Resident #3's regular lunch meal was tested , and a replacement was ordered. The cheeseburger on the test tray measured at 112 degrees Farenheit, carrots measured at 111degrees Farenheit, milk measured at 55 degrees Farenheit and the pudding measured at 65 degrees Farenheit. During an interview on 6/11/2024 at 12:05 PM with [NAME] #10, they stated the food served to residents should be hot when it went out like the food from the steam table. They did not know the required temperature ranges of food. During an interview on 6/11/2024 at 2:05 PM, the Administrator, who was also serving as the acting Food Service Director, stated food should be served at 140 degrees Farenheit to residents. They were not sure if there was a policy for palatability of foods. 10NYCRR 415.14(d)(2)

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	335077	A. Building B. Wing	06/13/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34459 46276 Based on observation, interview and record review during the recertification survey conducted 6/10/2024 -6/13/2024, the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety in 1 of 1 main kitchen. Specifically, the floors under the dish machine and the walk-in cooler were unclean with food debris and there was brown liquid spilled on the walk-in cooler floor. Findings include: The 5/14/2024 dietary checklist documented daily tasks to be completed every shift included sweeping the floor, and evening tasks included sweeping and mopping the floor and walk-in cooler. A quarterly deep cleaning schedule documented areas deep cleaned for June 2024 were the dishwasher area, walk-in refrigerator, and stove hood. During an observation on 6/10/2024 at 9:44 AM in the main kitchen, the floors under the dish machine were unclean with food debris. The floors in the walk-in cooler were unclean with food debris and they had a brown liquid spilled on them. Mouse traps were observed on the dry food storage shelves. During an observation on 6/11/2024 at 11:45 AM in the main kitchen, the floor in the walk-in cooler remained soiled with food debris and the brown liquid spill, and the floors under the dish machine and bay 3 remained soiled with food debris. During an interview on 6/11/2024 at 11:46 AM with [NAME] #10, they stated the kitchen staff tried to clean every day and the cooler could use more cleaning. During an interview on 6/11/2024 at 2:05 PM with the Administrator they stated they were the acting Food Service Director until one could be hired; they expected daily cleaning of the floors in the main kitchen and they performed monthly deep cleanings which included the walk-in cooler. 10NYCRR 415.14(h)