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

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and interviews during the recertification survey conducted 9/22/2025-9/25/2025, the facility did not ensure there were services of a Registered Nurse for at least eight consecutive hours, seven days a week. Specifically, the facility did not provide eight (8) consecutive hours of Registered Nurse coverage on 9/6/2025, 9/14/2025, 9/15/2025-9/18/2025, and 9/21/2025 as required, and did not have a waiver. Findings include:The Facility Assessment, revised 4/22/2025, documented the number of licensed beds was 40, and the average daily census was 35. The facility resources needed to provide competent resident support and care daily and during emergencies was: 1 Director of Nursing, 1 Assistant Director of Nursing, 1 Infection Preventionist, 2 Registered Nurses, 7 Licensed Practical Nurses, and 15 Certified Nursing Assistants. Additionally, federal law required nursing homes had sufficient staff to meet the needs of residents and included services of a Registered Nurse for at least 8 consecutive hours a day, 7 days a week. During an entrance conference interview on 9/22/2025 at 7:36 AM, the Administrator stated the facility had no nursing staff waivers and there was registered nurse coverage when the Director of Nursing was not in the building.Review of the September 2025 registered nurse daily timecards documented there was no registered nurse coverage on 9/6/2025, 9/14/2025, 9/15/2025-9/18/2025, and 9/21/2025. During an interview on 9/25/2025 at 12:53 PM, the Director of Nursing stated they were the only registered nurse for the facility since 8/14/2025. They were out from 9/15/202-9/17/2025 and there was nobody to cover for them. They were also off on weekends. They thought Registered Nurse #15 covered on the weekends. During an interview on 9/25/2025 at 2:20 PM, the Administrator stated they did not currently have a registered nurse Unit Manager and that was who covered on the weekends. Sometimes the registered nurse Minimum Data Set Coordinator picked up some supervision shifts on the weekends. Registered Nurse #15 sometimes also picked up weekend shifts but had not done so in long time. They were not sure if there was registered nurse coverage when the Director of Nursing was out sick. It was their responsibility, and the Director of Nursing's responsibility the regulations were met. A registered nurse was required 8 hours a day, 7 days a week and they were not sure if they always met that requirement. They were trying to hire another registered nurse, but it had been difficult. 10NYCRR 415.13(b)(1)

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations and interviews during the recertification survey conducted 9/22/2025-9/25/2025, the facility did not ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles for two (2) of two (2) medication carts (Sides 1 and 2 medication carts), one (1) of one (1) medication room, and one (1) of one (1) treatment cart reviewed. Specifically, the Side 1 medication cart contained medications that were not dated when opened, and expired medications; the Side 1 and Side 2 medication carts and treatment cart were unlocked and unattended; and the medication room refrigerator was unclean and had a large buildup of ice on the back. Findings include:The facility policy Storage, Labeling of Over-the-Counter Medication, Destruction and Disposal of Medication, revised 9/3/2025, documented medications and biologicals were stored safely and securely. Medications should be labeled accordingly and missing, incomplete, improper, or incorrect containers shall be returned to the dispensing pharmacy for proper labeling before storing. Expired medications were removed from medication carts prior to or at the time of expiration. Medications were stored in accordance with the manufactures guidelines and not to exceed the expiration dates unless a medication had shortened shelf life once opened. Eye drops were independent use only and should have the residents record number and date of opening. Unlocked medication and treatment carts:During an observation on 9/22/2025 at 6:27 AM, the Side 1 and Side 2 medication carts and treatment cart were unlocked and unattended. The carts were lined up on the opposite side of the nurse's station. During observations on 9/22/2025 the treatment cart was unlocked and unattended at 7:26 AM, 7:59 AM, 8:12 AM, and 9:52 AM. The cart contained scissors, ketoconazole (antifungal) shampoo, ketoconazole (antifungal) cream, triamcinolone (steroid) cream, lidocaine (pain) cream, Theraderm (moisturizer), estradiol (hormone) cream, silver nitrate sticks, ace wraps, oxygen tubing, and razors. Residents were sitting in the area. The treatment cart was observed unlocked and unattended on 9/24/2025 at 11:05 AM, on 9/25/2025 at 9:07 AM and 12:45 PM. Medication room: During an observation and interview on 9/22/2025 at 10:07 AM, the medication room refrigerator had a significant buildup of ice on the back, a discolored white towel on the bottom shelf, spilled white substance on the bottom shelf and spilled brown substance on the bottom shelf. Registered Nurse #17 stated they observed the ice buildup and was not sure who took the refrigerator temperatures or where they were documented to ensure the ice buildup was not impacting temperatures. Medications stored in the refrigerator had to be held at certain temperatures to ensure they were safe for administration. Registered Nurse #17 stated they were not sure why there was a dirty towel in the refrigerator, but it should not be there. They believed the spilled debris was pudding and Boost (nutritional supplement). They stated the refrigerator should always be clean for infection control and safety reasons. Medication cart: During an observation on 9/22/2025 at 10:25 AM, medication cart Side 1 contained the following:-one bottle of artificial tears eye drops for Resident #37 that was not dated when opened.-one Ventolin inhaler for Resident #37 that was not dated when opened. The dispense date was 3/26/2025.-one Albuterol inhaler for Resident #37 that was not dated when opened.-one Albuterol inhaler for Resident #1 that was not dated when opened.-one Albuterol inhaler for Resident #9 that was not dated when opened.During an interview on 9/22/2025 at 10:25 AM, Registered Nurse #17 stated the medication cart and treatment cart should always be locked when unattended to prevent residents, staff, or visitors from having access. The treatment cart also contained medicated shampoos, creams, and patches and should be locked for the safety of residents. Inhalers did not require an open date and were discarded when they were empty. Eye drops required a date when they were opened and the artificial tears for Resident #37 were not dated and should have been. During an interview 9/25/2025 at 9:18 AM, the Director of Nursing stated the medication room should be clean and neat. Stock should be rotated and expired medications (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discarded. The refrigerator should be clean and not have ice buildup. The ice buildup might not allow for proper temperatures of the medications in the refrigerator which could make them less effective. They expected insulin, eye drops and inhalers to be dated when opened and both insulin and eye drops expired in 28 days. Inhalers expired in 42, 45, and 90 days depending on the inhaler. Any opened inhaler that was not labeled and dispensed in March should be thrown out. Expired medications may not be as effective. The medication and treatment carts should be locked if unattended to avoid potential harm as there were residents who wandered. 10NYCRR 415.18(d)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 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 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 11/1/2024. Registered Nurse #16 signed the ceftriaxone was administered on 11/3/2024 at 7:43 PM, 11/14/2024 at 3:17 PM, 11/19/2024 at 5:48 PM, and 11/20/24 at 4:10 PM. The Medication Administration Record documented blanks for administration on 11/1/2024, 11/2/2024, 11/4/2024, 11/8/2024, 11/1/2024, and 11/16/2024. There were no corresponding nursing progress notes for the omitted antibiotics. A 11/26/2024 narrative completed by former Director of Nursing #6 documented a licensed practical nurse (unnamed) made them aware of intravenous medications not given as ordered. Investigation determined Resident #45 had several days of documentation missing for their antibiotics. 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 a number of intravenous antibiotics 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 Director of Nursing noticed their own initials were signed on the 11/15/2024 medication administration record for ceftriaxone and Registered Nurse #16 denied using the initials. 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. During an interview on 9/24/2025 at 1:21 PM, Licensed Practical Nurse #11 stated if a medication was not signed for it was not administered and they would report it to the Assistant Director of Nursing or the supervisor. Registered nurses administered all intravenous antibiotics. If they noticed an intravenous antibiotic was not signed for, they would 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. Resident #32 not receiving their clonazepam as ordered and Resident #45 not receiving their intravenous antibiotic as ordered should have been investigated. They were not employed by the facility at the time of the incidents with Resident #32 or Resident #45. Incidents like this were reported to the Department of Health by the Administrator. They were not sure if this was reported to the Department of Health as they were not employed by the facility at the time. 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 do not recall Resident #32 as some time had passed. They did recall Resident #45. They expected Resident #45 to receive their intravenous antibiotic that was ordered for an infection to the finger that required a partial amputation. They were not notified the resident did not have their antibiotic administered. If they were notified of a missed antibiotic dose, they would have changed the order to have it be given intramuscularly. If a resident did not receive intravenous antibiotics, it would be a significant medication error. If the nurse did not notify them and did not get an intramuscular order to have it replaced with, it would be neglect. Without the antibiotic the resident may have required additional amputation. During an interview on 9/24/2025 at 3:20 PM, former Director of Nursing #6 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident #45 had a finger amputation and arrived back at the facility with a peripherally inserted central catheter and intravenous antibiotics. Licensed practical nurses were not allowed to administer intravenous antibiotics and registered nurses performed all the care for peripherally inserted central catheters. When they found the medication administration was missing, they notified the physician, however they did not recall if they documented that. They did not recall if other medication administration records for other residents in the facility were reviewed. They did not know if neglect was ruled out because they were not able to continue the investigation as it was taken over by the Administrator. They did not recall anything regarding Resident #32's clonazepam as some time had passed. They were not sure if Registered Nurse #16 had been reported to the state for falsification of documentation, but they should have been.During an interview on 9/25/2025 at 1:00 PM, the Administrator stated they had training on abuse and neglect. They were responsible for reporting certain specific cases of abuse and neglect to the Department of Health. They were the facility Administrator at the time of the medication errors with both Resident #45 and Resident #32. The investigation started with former Director of Nursing #6 and they took over. They were not sure what was done to ensure medications were not missed for other residents. They were not sure if the missed administrations was neglect, however it was a significant medication error. Significant medication errors were reported to the state; however, they did not report it as they were new to their roll and was going through a rough situation. In hindsight they would have done things differently. 10NYCRR 415.4(b)(3)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the activities program is directed by a qualified professional. Based on record review and interviews during the recertification survey conducted 9/22/2025-9/25/2025, the facility did not ensure the activities program was directed by a qualified person responsible for directing the development, implementation, supervision and ongoing evaluation of the activities program. Specifically, Director of Activities #9 was not qualified to direct the provision of activities to the residents. Findings include:The facility's Director of Activities Job Description undated documented the Director of Activities is responsible for planning, organizing, staffing, directing, coordinating, reporting, budgeting, and physical management of the activities department's employees and equipment to implement an on-going diversified program of activities to meet the individual resident's needs. The Director of Activities reports directly to the Administrator. Qualifications for the job include high school education or equivalent with additional training (B.A. or B.S. in Recreational Therapy, Occupational Therapy, Education or Social Service Preferred) in related areas. Three years of experience in activities in group programming or equivalent; with some supervisory experience preferred. The 9/22/2025 Facility Survey Report documented Activities Director did not have the qualified professional credential and experience including, Therapeutic Recreation Specialist Certification, and did not have two years of age- appropriate experience within the last five years, one of which was full time in a patient activities program in a health care setting, or Registered Occupational Therapist or Certified Occupation Therapist Assistant.During an interview on 9/25/2025 at 12:46 PM, the Activity Director stated they were in their role since August 2025. They had a high school diploma and no official background in recreational therapy. They were responsible for making the monthly calendar, planning events to engage the residents socially, emotionally, physically, and spiritually. They do not attend the any resident care plan meeting. They completed the activities portion of the Minimum Data Set. They started their employment as a cook one year ago and was promoted to Kitchen director for 6 months, then moved to Director of Activities. They stated their previous work experience was at a cafe for 8 years where they helped with ordering supplies. During an interview on 9/25/2025 at 1:00 PM, the Administrator stated their background was social work and activities. They stated the Activity Director started in November or December last year and became the Activity Director in August 2025. They were unable to state what their credentials were for the position of Activity Director. They stated the Activity Director is one of their best employees, and has been shown how to do progress notes, care plans and assessments. 10 CRR- NY415.5 f (2)(1-3)

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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 review, and interviews during the recertification survey conducted 9/22/2025-9/25/2025, the facility did not ensure residents received treatment and care in accordance with professional standards of practice for one (1) of one (1) resident (Resident #5) reviewed. Specifically, Resident #5 had wound treatment order changes that were not implemented, did not have weekly wound follow-up as recommended, and the wounds to the right foot were not included in the comprehensive care plan. Findings include: The facility policy Skin Prevention, Assessment and Treatment, revised 5/2/2022, documented any skin impairments were assessed and documented weekly in the medical record by the wound nurse, or designee. The goal of wound treatments was to promote healing. Residents with wounds were reviewed during weekly Risk Management Committee meetings for progress and interventions and care plans were revised as appropriate. Resident #5 had diagnoses including methicillin resistant staphylococcus aureus infection (a type of bacteria resistant to many antibiotics), Stage 4 pressure ulcer (full thickness tissue loss) of left heel, and non-pressure chronic ulcers of left heel and midfoot. The 8/14/2025 Minimum Data Set assessment documented the resident was cognitively intact, had one unhealed Stage 4 pressure injury upon admission or reentry, two venous and atrial ulcers, and had application of dressings to feet. Physician orders documented:-On 8/19/2025 right dorsum foot: cleanse with wound cleanser, pat dry, apply calcium alginate (creates a moist gel-like covering) to wound bed only (do not apply to healthy skin), cover with blue super absorbent dressing, wrap with kerlix (gauze roll), every other day and as needed if soiled or missing dressing.-On 8/25/2025 left dorsum: cleanse with wound cleanser, pat dry, apply calcium alginate to wound bed only (do not apply to healthy skin), cover with blue super absorbent dressing, wrap with kerlix, change dressing every other day and as needed if soiled or missing dressing. -On 8/25/2025 right ankle: cleanse with wound cleanser, pat dry, apply xeroform gauze (a petroleum non-stick gauze), wrap with kerlix, change every other day and as needed if soiled or missing dressing,-On 8/25/2025 soak both feet in warm water and Epsom salts for 20-30 minutes every other day prior to dressing changes. The Comprehensive Care Plan initiated 11/9/2023, and revised 3/29/2025, documented the resident had actual impairment to skin integrity of the left dorsal (top) foot related to non-pressure wound. Interventions included weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. The care plan did not include the wounds to the right dorsal foot or the right ankle. The 9/4/2025 Physician #20 Wound Care Telemedicine follow up evaluation documented the following dressing treatment plans:-Stage 4 pressure wound of the left dorsal foot, add leptospermum honey (medical grade honey), continue soak foot at time of dressing change, discontinue calcium alginate, continue absorbent pad and kerlix gauze roll every two days and as needed if saturated, soiled, or dislodged.-Non-pressure wound of the right anterior ankle, continue xeroform gauze, continue kerlix gauze roll once daily and as needed if saturated, soiled, or dislodged. -Non-pressure wound of the right dorsal foot, add leptospermum honey, continue soak foot at time of dressing change, discontinue alginate calcium, continue absorbent pad, kerlix gauze roll, and skin prep around peri wound every 2 days and as needed if saturated, soiled, or dislodged. -The resident's plan of care was discussed with nursing staff member (unidentified).-Follow up evaluation by wound care provider weekly, or sooner as needed, with further intervention based on response to current treatment plan. There was no documented evidence the 9/4/2025 Physician #20 treatment plan was implemented. There was no documented evidence the resident was evaluated by the wound care provider weekly since the last visit on 9/4/2025. During an observation and interview on 9/24/2025 at 2:48 PM, Resident #5 was in their wheelchair in their room, their feet were soaking in a basin with the dressings on. Licensed Practical Nurse #3 stated the resident first soaked their feet in Epson salts for 20 minutes prior to dressing changes and had set a timer. The nurse emptied the foot soak. The dressings to the bilateral feet were dated 9/22/2025. Licensed Practical Nurse #3 took the kerlix (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wraps and blue absorbent dressings off both feet and xeroform off the right ankle. Licensed Practical Nurse #3 stated the three dressings were changed every other day. The nurse and the resident both stated the wounds were improving. The right ankle, as well as the tops of the right and left feet were cleansed with wound cleanser. Calcium alginate was applied to the open area on the top of the left foot, covered with blue absorbent dressing and wrapped with kerlix. Xeroform was applied to the right ankle and calcium alginate was applied to the top of the right foot. Blue absorbent dressing was applied to the top of the right foot and wrapped with kerlix. The resident stated they saw wound care providers over the phone and were due to see them again tomorrow. During an interview on 9/25/2025 at 11:54 AM, the Director of Nursing stated they conducted wound rounds on Thursdays using an IPAD from an outside company that saw the residents virtually. The outside wound company had access to the electronic medical record and uploaded their evaluations usually before the next day. They were responsible to ensure the evaluations were reviewed, and the orders/ dressing treatment plans were updated. The resident was last seen on 9/4/2025 and there were treatment changes. They stated they must have been pulled away because they remember reviewing the changes, but they never updated the orders. They were the only registered nurse for the building. The resident had not been seen since 9/4/2025 because on 9/11/2025 the outside wound company did not have a provider available for wound rounds and they were out sick last week and there was nobody to cover for them. On 9/25/2025 at 12:29 PM, an attempt was made to interview Physician #20. There was no return telephone call. During an interview on 9/25/2025 at 12:20 PM, the Administrator stated the Registered Nurse Unit Manager was responsible to ensure the wound notes were reviewed and the treatment orders were updated but they did not have a Registered Nurse Unit Manager right now. Any nurse could enter an order so the Director of Nursing should be asking for help from the licensed practical nurses. They were not sure what the current process was. 10NYCRR 415.12

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	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

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observations, record review, and interviews during the recertification survey conducted 9/22/2025-9/25/2025, the facility did not ensure residents maintained acceptable parameters of nutritional status for one (1) of one (1) Resident (Resident #31) reviewed. Specifically, Resident #31 had significant weight loss and did not receive their planned nutritional supplement or a comparable substitution.Findings include:The facility policy Weight Assessment and Interventions, revised 12/30/2024, documented the dietitian assessed resident nutrition, food preferences, food allergies, frequency of meals and cultural/religious preferences on the initial and annual assessment. Nursing staff measured resident weights on admission and then weekly for four weeks. If no weight concerns, weights were measured monthly. Recommendations from the provider and/or dietitian were followed. Interventions for undesirable weight loss focused first on food (extra food, snacks, calorie-dense food). The facility policy Nutritional Snacks and Supplements, revised 12/30/2024, documented members of the interdisciplinary team such as speech therapist, nurse, and dietitian made recommendations and/or obtained orders from the physician for nutritional supplements. Nursing staff delivered supplements and snacks to the residents and notified the dietitian of any supplements that were not accepted by residents for evaluation. Supplements were incorporated in care plans as needed.Resident #31 had diagnoses including protein-calorie malnutrition and vitamin D deficiency. The 6/9/2025 Minimum Data Set assessment documented the resident had moderately impaired cognition, had a poor appetite, required partial/moderate assistance with eating, weighed 119 pounds, had 5% or more weight loss in the last month or 10% or more in the last six months, and was not on a prescribed weight loss program.The 7/2/2025 physician order documented the resident was to receive a regular diet with nectar thick consistency liquids. The resident's weight record documented the following weights:-3/3/2025, 135 pounds -4/8/2025, 124.5 pounds -5/3/2025, 127 pounds -6/3/2025, 115 pounds with a repeated weight of 118.5 pounds (6.7% weight loss in one month).The 6/10/2025 Registered Dietitian #19 progress note documented they discontinued the Mighty Shake (nutritional supplement) and would trial Magic Cups (frozen nutritional supplement) to prevent further weight loss.The 7/8/2025 Comprehensive Care Plan documented the resident had a nutrition problem. Interventions included provide resident super cereal (fortified cereal) and two Magic Cups at lunch.The following observations were made:- On 9/22/2025 at 12:21 PM the resident was in the dining room for lunch. The resident's lunch included a taco, applesauce, water, apple juice, milk, coffee, and bean salad. The resident's meal ticket documented Magic Cup at lunch (did not indicate two Magic Cups). There was no Magic Cup on the meal tray. At 12:55 PM the resident attempted to drink their applesauce.- On 9/23/2025 at 12:23 PM the resident was in the dining room for lunch. The resident's meal ticket documented Magic Cup at lunch. There was no Magic Cup on the meal tray. At 12:42 PM Resident #31 stated if they were given ice cream, they would eat it.- On 9/24/2025 at 12:25 the resident's lunch tray included milk, apple juice, chicken parmesan bites, noodle bites, and cake. The resident's meal ticket documented Magic Cup at lunch. The tray was missing coffee, mixed vegetables, and the Magic Cup. Resident #31 stated they would eat the Magic Cup if they had it.During an interview on 9/24/2025 at 2:46 PM, Certified Nurse Aid #10 stated staff who handed out the trays to the residents were responsible for ensuring everything on the trays was correct. The kitchen placed the Magic Cups on the resident trays if they were on the meal ticket. They did not think Resident #31 was supposed to receive Magic Cups at lunch but if their meal ticket listed Magic Cups, they should get them because they did not eat a lot. During an interview on 9/24/2025 at 2:52 PM, Licensed Practical Nurse #11 stated the person who takes the tray off the cart was responsible for making sure the tray was correct. If a resident was supposed to have a Magic Cup, the kitchen placed it on their tray. Resident #31 was losing weight. They did not know if Magic Cups were on the resident's care plan or meal ticket but if they were supposed to have Magic Cups they should receive them.During an interview on 9/25/2025 at 10:10 AM, Director of Nursing #2 stated they spoke with the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dietary Manager and was notified they were out of Magic Cups all week and substituted with applesauce. During an interview on 9/25/2025 at 11:11 AM, Director of Dietary #12 stated they made sure all items were on resident trays. There was one resident who was supposed to receive Magic Cups. The resident did not receive the Magic Cups because they were out of them. A resident who required nectar thick liquids received Magic Cups because they could not have ice cream. When they were out of Magic Cups they usually substituted with Mighty Shakes (fortified milk shake), but since they were also out of those, they substituted applesauce. Applesauce was not nutritionally equivalent to a Magic Cup or Mighty Shake. They notified the registered dietitian. During an interview on 9/25/2025 at 12:03 PM. Registered Dietitian #13 stated they monitored for weight loss and if weight loss was noted, they recommended supplements, fortified foods, and talking with the resident to understand why they were not eating. When someone needed a supplement, they put in an order and added it to the care plan. If Magic Cups were recommended, they expected the resident to receive them. Applesauce was not nutritionally equivalent to Magic Cups and was not an acceptable substitute. Resident #31 had weight loss and Magic Cups were added to prevent further weight loss. 10NYCRR 415.12(i)1

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Resident #45 to receive their ordered intravenous antibiotic for an infection to the finger that required a partial amputation. They were not notified the resident did not have their antibiotic administered. If they were notified of a missed antibiotic dose, they would change the order to have it administered intramuscularly. If a resident did not receive intravenous antibiotics, it would be a significant medication error. Without the antibiotic the resident may have required additional amputation. During an interview on 9/24/2025 at 3:20 PM, former Director of Nursing #6 stated Resident #45 had a finger amputation and arrived back at the facility with a peripherally inserted central catheter (venous access) and intravenous antibiotics. Licensed practical nurses were not allowed to administer intravenous antibiotics and registered nurses performed all the care for peripherally inserted central catheters. When they found the medication administration was missing, they notified the physician, however they did not recall if they documented that. They did not recall if other medication administration records for other residents in the facility were reviewed. They did not recall anything regarding Resident #32's clonazepam as some time had passed. They were not sure if Registered Nurse #16 was reported to the state for falsification of documentation, but they should have been.An attempt to contact Registered Nurse #16 on 09/25/2025 at 3:43 PM was unsuccessful. The number provided by the facility was no longer in service. 10NYCRR 415.12(m)(2)