STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395514	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maybrook Hills Rehabilitation and Healthcare Cente	301 Valley View Boulevard Altoona, PA 16602

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** Based on review of policies, clinical records, observations and staff interviews, it was determined that the facility failed to implement interventions in a resident's care plan to prevent a wandering resident from entering other's rooms for six of 19 residents reviewed (Residents 13, 14, 15, 16, 17, 18).Findings include: The facility's policy regarding care plans, dated June 10, 2026, revealed that the resident's care plan will address resident goals, actual and potential problems, needs, strengths and individual preferences of the resident. A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 19, dated June 15, 2026, revealed that the resident was severely cognitively intact, ambulated without assistance, and had wandering behaviors. The resident's care plan, most recently updated 6/26/26, revealed that she wanders and that she would not significantly intrude on the privacy or activity of others. Observations of Resident 19 on June 30, 2026, revealed that the resident was walking the halls of the [NAME] 1 floor and wandering aimlessly. A quarterly MDS assessment for Resident 13, dated May 9, 2026, indicated that the resident was severely cognitively impaired, required assistance for daily care needs, and had diagnoses that included anxiety. The resident's care plan, dated November 17, 2025, revealed that she is to have a stop sign on her room door to maintain privacy and that staff will observe placement of stop sign during rounds. Observations of Resident 13 in room [ROOM NUMBER] on June 30, 2026, at 1:00 p.m. revealed that she was laying in her bed in her room and the stop sign at her doorway was not engaged. A quarterly MDS assessment for Resident 14, dated March 27, 2026, revealed that the resident was cognitively intact. The resident's care plan, dated June 10, 2025, revealed that she was to have a stop sign on her door to maintain privacy and that staff would observe the placement of the stop sign during rounds. Observations of Resident 14 in room [ROOM NUMBER] on June 30, 2026, at 1:11 p.m. revealed that she was sitting at the side of her bed and that the stop sign was not engaged on her doorway. A quarterly MDS assessment for Resident 15, dated May 29, 2026, revealed that the resident was cognitively intact and required assistance from staff for all her daily care needs. The resident's care plan, dated April 18, 2024, revealed that the resident is to have a stop sign at her doorway. Observations of Resident 15 in room [ROOM NUMBER] on June 30, 2026, at 1:11 p.m. revealed that the resident was laying in her bed and her stop sign was not engaged on her doorway. A quarterly MDS assessment for Resident 16, dated March 27, 2026, revealed that the resident was severely cognitively impaired and required assistance from staff for her daily care needs. The resident's care plan, dated June 10, 2025, revealed that she was to have a stop sign at her door to maintain privacy and that staff would observe placement of the stop sign during rounds. Observations of Resident 16 in room [ROOM NUMBER] on June 30, 2026, at 1:11 p.m. revealed that she was lying in her bed and that the stop sign was not engaged on her door. A quarterly MDS assessment for Resident 17, dated May 31, 2026, revealed that the resident was severely cognitively impaired and required assistance from staff for her daily care needs. The resident's care plan, dated October 15, 2025, revealed that the resident was to have a stop sign at her door to maintain privacy and that staff would observe placement of stop sign during rounds. Observations of Resident 17 in (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395514	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maybrook Hills Rehabilitation and Healthcare Cente	301 Valley View Boulevard Altoona, PA 16602

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	room [ROOM NUMBER] on June 30, 2026, at 1:13 p.m. revealed that she was laying in her bed and the stop sign was not engaged on her door. A quarterly MDS assessment for Resident 18, dated May 3, 2026, revealed that the resident was severely cognitively impaired and required assistance from staff for her daily care needs. The resident's care plan, dated August 27, 2025, revealed that the resident was to have a stop sign on her door to maintain privacy and that staff would observe placement of stop sign during rounds. Observations of Resident 18 in room [ROOM NUMBER] on June 30, 2026, at 1:13 p.m. revealed that she was lying in her bed and the stop sign was not engaged on her door. Interview with Nurse Aide 1 and Nurse Aide 2 on June 30, 2026, at 1:10 p.m. revealed that they were agency nurse aides and that they believed the resident's stop signs only had to be up at certain times of the day and that when they charted regarding the stop sign they were signing off that the stop sign was at the door, not that it was engaged at the resident's door. Interview with Licensed Practical Nurse 3 on June 30, 2026, at 1:20 p.m. revealed that the residents stop signs should be engaged in order to prevent Resident 19, or other wandering residents, into their rooms. She walked around the halls and placed the stop signs across from the residents' rooms. Interview with the Director of Nursing on June 30, 2026, at 3:10 p.m. revealed that he put the stop signs in their proper place earlier this day, but that staff or residents may have taken them down since that time. He stated that they should be in place in order to prevent a wandering resident from entering their rooms. He further stated it may not be the best intervention since other residents tend to tear them down. 28 Pa. Code 211.11(d) Resident care plans. 28 Pa. Code 211.12(d)(1)(5) Nursing services.