STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395985	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midtown Oaks Health & Rehab Center	1020 Green Avenue Altoona, PA 16601

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 48941 Based on clinical record reviews and staff interviews, it was determined that the facility failed to accommodate residents' preferences regarding showers for two of nine residents reviewed (Residents 5, 8). Findings include: An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated February 20, 2024, revealed that the resident was sometimes understood, sometimes understands, and had a diagnosis which included dementia and Alzheimer's disease. A care plan for the resident, dated November 29, 2023, revealed that she required assistance with care tasks and preferred to shower. Nurse aide shower assignments for Resident 5, undated, revealed that the resident was to receive a shower every Tuesday and Saturday. Shower records for Resident 5, dated February, March, and April 2024, revealed that on February 10, 17, 20, 24, and 27, 2024; March 16, 19, and 26, 2024; and April 2, 6, and 9, 2024, the resident received a bed bath and did not receive a shower as she preferred. A quarterly MDS assessment for Resident 8, dated February 1, 2024, revealed that the resident was cognitively intact, sometimes understands, and had a diagnosis which included dementia. A care plan, dated July 3, 2023, revealed that Resident 8 preferred to shower. Nurse aide shower assignments for Resident 8 revealed that the resident was to receive a shower every Monday and Thursday. Shower records for Resident 8, dated February, March, and April 2024, revealed that the resident was not showered according to her preference on February 8, 12, 15, 19, 22, and 26; March 4, 7, 11, 18, 21, and 25; and April 1, 4, 8, 11, 15 and 18, 2024. Interview with the Director of Nursing and the Assistant Director of Nursing April 18, 2024, at 5:25 p.m. confirmed that there was no documented evidence of why Resident 5 and 8 were provided bed baths instead of a shower as preferred. 28 Pa. Code 201.29(j) Resident Rights. (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
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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(5) Nursing Services.

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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 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. 48941 Based on review of facility polices and clinical record reviews, as well as staff interviews, it was determined that the facility failed to develop a plan of care to address a resident's psychosocial well-being related to her fear and not feeling safe after a resident-to-resident incident for one of nine residents reviewed (Resident 7). Findings include: The facility's policy regarding care plan development, dated January 1, 2024, indicated that an interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis to meet the resident's medical, nursing, and mental and psychosocial needs. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) assessment for Resident 7, dated March 19, 2024, revealed that the resident was cognitively intact, was understood and could understand, had no behaviors, and required assistance with care needs. A nursing note for Resident 7, dated April 14, 2024, at 5:30 a.m., revealed that she reported she had laid down in bed after going into the restroom. She was adjusting the placement of her walker with one of her assistive devices and Resident 4 came out of the bathroom and into her room and walked over toward her. She told Resident 4 to go back to her own room, but the resident continued to walk toward her. Resident 4 accused Resident 7 of hitting her with the assistive device and grabbed her by the wrists and squeezed them. They were separated by one of the nurses. Upon assessment, Resident 7's right lateral wrist was noted to have a dark, pea-sized bruise with no open skin. She also reported some discomfort to her wrist. Interview with Resident 7 on April 18, 2024, at 12:22 p.m. revealed that Resident 4 from next door came in a few nights ago and grabbed her when she was in bed. She stated that Resident 4 came in through the bathroom and told her to get out that this was her house and her bed. Resident 7 stated that Resident 4 still comes into her room, even though there is a stop sign on the bathroom door, and that she no longer feels safe. She stated that Resident 4 also came in her room and went through her closet and drawers. There was no documented evidence to indicate that a care plan was developed to address Resident 7's psychosocial well-being related to her fear of not feeling safe after the resident-to-resident incidents. Interview with the Director of Nursing on April 18, 2024, at 3:20 p.m. confirmed that there was no care plan in place to address Resident 7's psychosocial well-being related to her fear and not feeling safe after the resident-to-resident incidents. 28 Pa. Code 201.24(e)(4) Admission Policy. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48941 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific behavioral intervention for one of nine residents reviewed (Resident 4). Findings include: The facility's policy regarding care plan development, dated January 1, 2024, indicated that an interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis to meet the resident's medical, nursing, and mental and psychosocial needs. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) assessment for Resident 4, dated April 1, 2024, revealed that the resident was cognitively impaired, walked independently without an assistive device, had wandering behaviors, and had a wander/elopement alarm used daily. A nursing note on April 15, 2024, at 9:47 a.m. revealed that the interdisciplinary team reviewed the incident of Resident 4 going into Resident 7's room through a shared bathroom. A stop sign was to be placed on the opposite bathroom door and a sign with the resident's name on her side. A psychosocial care plan to address Resident 4's wandering behavior, initiated on November 14, 2023, included interventions to assess whether the behavior endangers the resident and/or others and intervene if necessary; maintain a calm environment and approach to the resident; when resident begins to wander, provide comfort measures for basic needs (e.g., pain, hunger, toileting, too hot/cold, etc.). There was no documented evidence that Resident 4's care plan was revised to reflect the intervention for the stop sign. Interview with the Director of Nursing on April 18, 2024, at 3:53 p.m. confirmed that Resident 4's care plan was not revised to reflect the intervention for the stop sign, and it should have been. 28 Pa. Code 201.24(e)(4) Admission Policy.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48941 Based on review of clinical records and facility reports, as well as staff interviews, it was determined that the facility failed to ensure that the residents' environment remained safe for two of nine residents reviewed (Residents 2, 4) and failed to conduct a thorough investigation of resident-to-resident altercations to determine if care-planned interventions were followed for one of nine residents reviewed (Resident 6). Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated January 26, 2024, revealed that the resident was cognitively impaired, had physical behaviors, wandered, had behavioral symptoms not directed toward others, was receiving antipsychotic and antidepressant medications, and had diagnoses that included dementia. A behavior care plan for Resident 2, revised March 18, 2024, revealed that staff were to recognize/anticipate when the resident was becoming agitated so they could redirect and provide support; distract the resident from wandering; staff would talk to resident about personal topics including his dog, his time in the navy, wife and two sons, sports, and driving truck as a method to redirect him when he was wandering into other residents' rooms; provide resident with a portable music player to help with redirection and encourage a soothing environment; monitor the location of the resident frequently, document wandering behavior, and attempted diversional interventions; provide diversional activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes; avoid over-stimulation (e.g., noise, crowding, other physically aggressive residents); maintain a calm environment and approach to the resident; if the resident was looking for family/significant other, re-assure the resident that family/significant other knows where to find the resident; place the resident in a secure environment; remove the resident from other resident's rooms and unsafe situations; when the resident begins to wander, provide comfort measures for basic needs (e.g., pain, hunger, toileting, too hot/cold, etc.); use affirmative words as opposed to no, don't, or stop; validate his reality and do not attempt to bring him into our reality; and administer medications as ordered by physician. A nursing note, dated January 21, 2024, at 7:15 p.m., revealed that the resident was in a fight with Resident 9 on the third floor common area known as the alcove. An interdisciplinary note, dated January 25, 2024, revealed that the residents' rooms were moved and Resident 2's Seroquel (anti-psychotic medication) was increased. A nursing note, dated March 16, 2024, at 4:08 p.m., revealed that the resident was in the common area with other residents and punched Resident 8 on the right buttock and hip. There was no documented evidence that an interdisciplinary meeting was held to address the incident or changes made to protect other residents at that time. The resident's care plan, dated March 18, 2024, was updated to have staff move the resident to a quiet room until the episode was resolved, remove potentially harmful objects from the immediate environment, and protect other residents in the immediate area from harm. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note, dated March 19, 2024, at 10:58 p.m., revealed that the resident was observed wandering into other resident's rooms and becoming agitated when medical staff tried to redirect him. The resident would open closed doors and go into other residents' rooms, and tear down magnetic stop signs. Staff were unable to redirect the resident, as the behavior would continue again in just a few minutes and he continued to become increasingly agitated and standoffish with all medical staff. A nursing note, dated April 4, 2024, at 22:03 p.m., revealed that Resident 2 walked by and aggressively bumped into Resident 1 with his shoulder and knocked the other resident to the floor. A facility event report, dated April 5, 2024, revealed that the resident would be referred to psychiatric services for a medication review. There was no documented evidence that any changes were made to Resident 2's behavior management plan. Following the above incidents, there was no documented evidence that Resident 2's care-planned behavior interventions were revised when they were not effective, and no evidence that an individualized behavior management plan was developed in an attempt to prevent Resident 2's behaviors from affecting the safety of all other residents. Interview with Nurse Aide 1 on April 18, 2024, at 12:20 p.m. revealed that Resident 2 wandered the unit a lot, would get agitated, hit other residents, shoulder checked another resident resulting in a fall for the other resident, and wandered into other resident rooms. She indicated that giving him something to do would help prevent him from wandering (such as rearranging the furniture in the alcove) and it really helped when his wife would come in to visit. She felt he wandered so much because he was trying to find his wife. Interview with the Director of Nursing on April 18, 2024, at 5:29 p.m. confirmed that Resident 2 did have behaviors and that the resident's behavioral plan was not revised to include effective interventions that would ensure the safety and protection of other residents from Resident 2's aggressive behaviors. A quarterly MDS assessment for Resident 4, dated April 1, 2024, revealed that the resident was cognitively impaired, walked independently without an assistive device, had wandering behaviors, had a wander/elopement alarm used daily, and had diagnosis including Parkinson's (a degenerative brain condition that affects muscle control and movement), dementia (progressive disease causing loss of cognitive functioning), and schizophrenia (a serious mental disorder that affects how people interpret reality). A psychosocial care plan to address Resident 4's wandering behavior, initiated on November 14, 2023, included interventions to assess whether the behavior endangers the resident and/or others and intervene if necessary; maintain a calm environment and approach to the resident; when resident begins to wander, provide comfort measures for basic needs (e.g., pain, hunger, toileting, too hot/cold, etc.). A mood care plan to address Resident 4's physically abusive behaviors, initiated on April 15, 2024, included interventions to assess whether the behavior endangers the resident and/or others and intervene if necessary, avoid over-stimulation (e.g., noise, crowding, other physically aggressive residents), maintain a calm environment and approach to the resident, and maintain a calm, slow, understandable approach with the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note, dated March 3, 2024, at 12:14 a.m., revealed that Resident 4 was found in room [ROOM NUMBER] wandering and attempting to undress. She was extremely confused and was seen ten minutes earlier outside of her room stating she was looking for the bathroom. She was escorted to the bathroom. She then stated she was getting a bath and attempted to undress. It was explained to resident that it was the middle of night, and she agreed to return to bed. She was found later wondering in and out of rooms. She was helped back to her room and into bed but continued to wander and attempted to undress. A nursing note on March 5, 2024, at 11:14 p.m. (recorded as late entry on March 7, 2024, at 5:15 a.m.) revealed that Resident 4 continued to wander without purpose on unit and was noted to be sitting on the roommate's bed and required verbal cues, much encouragement, and detailed instructions to stand and go to her own bed. A nursing note on March 7, 2024, at 11:55 p.m. revealed that Resident 4 aimlessly wandered around the nursing unit, walked into other resident's rooms, and attempted to open closed doors. A nursing note on March 21, 2024, at 1:54 p.m. revealed that social services and the registered nurse assessment coordinator spoke with Resident 4's son about a room change due to her increased behaviors. The son was agreeable to the room change to third floor closer to the nurse's station. A nursing note for Resident 7, dated April 14, 2024, at 5:30 a.m., revealed that Resident 7 stated she had laid down in bed after going into the restroom and she was adjusting the placement of her walker with one of her assistive devices. She said Resident 4 came out of the bathroom door and into her room and walked over toward her. She said she told Resident 4 to go back to her room, but she continued to walk toward her, then Resident 4 reportedly accused Resident 7 of hitting her with the assistive device. Resident 7 reported that Resident 4 grabbed her by the wrists and squeezed them. She reported they were separated by one of the nurses. Upon assessment, Resident 7's right lateral wrist was noted to have a dark, pea-sized bruise with no open skin. She also reported some discomfort to her wrist. A nursing note for Resident 4, dated April 14, 2024, at 5:35 a.m., revealed that Resident 4 was in Resident 7's room and grabbed onto Resident 7's bilateral wrists and squeezed them. Assessment of Resident 4 revealed no injuries. A nursing note on April 15, 2024, at 9:47 a.m. revealed that the interdisciplinary team reviewed the incident of Resident 4 going into Resident 7's room through a shared bathroom. A stop sign was to be placed on the opposite bathroom door and a sign with the resident's name on her side. Resident 4 was unable to be reeducated due to dementia and psych diagnosis. Staff was to continue to provide support and redirection. Interview with Resident 7 on April 18, 2024, at 12:22 p.m. revealed that Resident 4 next door came in a few nights ago and grabbed her when she was in bed. Resident 7 stated Resident 4 came in through the bathroom and told her to get out, that this was her house and her bed. Resident 7 stated that she still comes into her room, even though there is a stop sign on the bathroom door. She stated that Resident 4 also came in her room through the doorway to her room and went through her closet and drawers. Resident 7 stated that she does not feel safe ever since the incident happened. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence that the interdisciplinary team assessed the effectiveness of the stop sign to prevent Resident 4 from wandering into Resident 7's room through the adjoining bathroom. There was no documented evidence that the interdisciplinary team addressed Resident 4's wandering into Resident 7's room through the doorway to her room, and no documented evidence that the interdisciplinary team addressed Resident 4's wandering into other resident's rooms. There was no documented evidence that an individualized behavior plan with individualized interventions was developed to prevent Resident 4's wandering and aggressive behaviors from affecting the safety of other residents. Interview with Nurse Aide 1 on April 18, 2024, at 12:36 p.m. revealed that she had observed Resident 4 entering Resident 7's room since the incident, and she stated that Resident 4 goes into a lot of rooms. Interview with the Director of Nursing on April 18, 2024, at 3:53 p.m. confirmed that Resident 4 does wander into other resident rooms, and there was no documented evidence that the intervention for the stop sign was assessed for effectiveness to ensure the safety and protection of Resident 7 and confirmed that there was no documented evidence that an individualized behavior plan with individualized interventions was developed to prevent Resident 4's behaviors from affecting the safety of other residents. A quarterly MDS assessment for Resident 6, dated February 5, 2024, revealed that the resident was understood and could understand others. A care plan for the resident, dated August 15, 2023, revealed that the resident has attention seeking behaviors towards males, and requested a stop sign across the door to prevent visitors from coming into her room. A note for Resident 6, dated April 10, 2024, revealed that the licensed practical nurse on the third floor made the writer aware that this resident reported hitting another resident with her back scratcher. The writer spoke with the resident, who reported that a confused male resident walked into her room, and she hit him on the wrist with her back scratcher. She said she told him to get out and hit him with it because she did not want him in there. The resident had no injury. The resident was educated to ring or yell out for assistance if the other resident enters her room again and she verbalized understanding. However, there was no documented evidence to indicate that a thorough investigation was conducted to determine if the stop sign was in place across Resident 6's door to prevent visitors from coming into her room. Interview with the Director of Nursing on April 18, 2024, at 5:30 p.m. confirmed that there was no documented evidence to indicate that an investigation was conducted to determine if the stop sign was in place across Resident 6's door to prevent visitors from coming into her room. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 211.12(d)(5) Nursing Services.

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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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. 48941 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident who displayed mental or psychosocial adjustment difficulties received appropriate treatment and services to correct the problem for one of nine residents reviewed (Resident 2). Findings include: The facility's behavior policy, dated January 1, 2024, revealed that the goal of the facility was to improve management of behaviors and move closer to the goal of ending any inappropriate or unnecessary use of antipsychotic medications. The facility would assess and track a behavior(s) that negatively impacted each resident in regards to their quality of life. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated January 26, 2024, revealed that the resident was cognitively impaired, had physical behaviors, other behavioral symptoms not directed toward others, wandered, was receiving and antipsychotic and antidepressant medications, and had diagnoses that included dementia. Physician's orders, dated January 20, 2024, included orders for the resident to receive 25 milligrams (mg) of quetiapine (antipsychotic medication) twice a day, 5 mg of olanzapine (antipsychotic medication) every twelve hours as needed for agitation, and 10 mg of donepezil (medication used to treat dementia) at bedtime. A nursing note, dated January 21, 2024, at 7:15 p.m., revealed that the resident was in a fight with Resident 9 on the third floor common area known as the alcove. A psychiatric consult, dated January 25, 2024, revealed that the resident was seen for anxiety and dementia with behavioral disturbances. Recommendations were made to discontinue the resident's Seroquel (quetiapine) and Zyprexa (olanzapine), and to start 0.5 mg of Risperdal (antipsychotic medication) twice a day and 0.5 mg of Ativan (antianxiety medication) every eight hours as needed for 14 days. However, there was no documented evidence that the resident's Seroquel and Zyprexa were discontinued or that Risperdal and Ativan were started. A nursing note, dated April 4, 2024, at 22:03 p.m., revealed that Resident 2 walked by and aggressively bumped into Resident 1 with his shoulder and knocked the other resident to the floor. A psychiatric consult, dated April 5, 2024, revealed that the resident was seen for anxiety and other behavioral disturbances. Recommendations were made to discontinue the resident's Zyprexa and donepezil, and to start 125 mg of Depakote (mood stabilizer) at bedtime and 0.5 mg of Ativan every eight hours as needed. However, there was no documented evidence that the recommendations were initiated until April 10, 2024 (five days later). (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note, dated April 10, 2024, at 9:50 a.m., revealed that the resident's wife called and asked if the resident's Depakote was ordered from the psychiatric visit on April 5, 2024. She was told that it was not ordered and requested the last psychiatric report be sent so they could see the recommendations. Interview with the Director of Nursing on April 18, 2024, at 5:29 p.m. revealed that recommendation from the psychiatric consult on January 25, 2024, were missed and not implemented, and the recommendations from the psychiatric consult on April 5, 2024, were delayed and not initiated until April 10, 2024. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0743 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a resident does not develop patterns of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless unavoidable. 48941 Based on clinical record reviews and facility reports, as well as staff interviews, it was determined that the facility failed to ensure that a resident did not display increased angry and aggressive behaviors by not following care-planned interventions for one of nine residents reviewed (Resident 6), resulting in the resident hitting another resident, and failed to evaluate appropriate treatment and services to maintain the resident's highest practicable physical and mental well-being by failing to address a resident's fear and not feeling safe after a resident-to-resident incident for one of nine residents reviewed (Resident 7). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated March 29, 2024, revealed that the resident was sometimes understood, sometimes understands, exhibited wandering daily, and had a diagnosis which included Alzheimer's disease and dementia. A care plan for the resident, dated March 20, 2024, revealed that the resident exhibited wandering behaviors. Staff were to remove the resident from other resident's rooms and unsafe situations. A quarterly MDS assessment for Resident 6, dated February 5, 2024, revealed that the resident was understood and could understand others. A care plan for the resident, dated August 15, 2023, revealed that the resident has attention-seeking behaviors towards males and requested a stop sign across the door to prevent visitors from coming into her room. A nursing note for Resident 6, dated April 10, 2024, revealed that the licensed practical nurse on the third floor made the writer aware that this resident reported hitting another resident (Resident 1) with her back scratcher. The writer spoke with the resident, who reported that a confused male resident walked into her room, and she hit him on the wrist with her back scratcher. She said she told him to get out and hit him with it because she did not want him in there. The resident had no injury. Resident 6 was educated to ring or yell out for assistance if the other resident entered her room again and she verbalized understanding. There was no documented evidence to indicate that the stop sign was across Resident 6's door to prevent Resident 1 from coming into her room. Interview with the Director of Nursing on April 18, 2024, at 5:30 p.m. confirmed that there was no documented evidence to indicate that the stop sign was across Resident 6's door to prevent Resident 1 from coming into her room. An annual MDS assessment for Resident 7, dated March 19, 2024, revealed that the resident was cognitively intact, was understood and could understand, had no behaviors, and required assistance with care needs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395985	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midtown Oaks Health & Rehab Center	1020 Green Avenue Altoona, PA 16601

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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 0743 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note for Resident 7, dated April 14, 2024, at 5:30 a.m., revealed that she reported she had laid down in bed after going into the restroom and was adjusting the placement of her walker with one of her assistive devices. She said Resident 4 came out of the bathroom and into her room and walked over toward her. She told Resident 4 to go back to her room, but she continued to walk toward her and accused Resident 7 of hitting her with the assistive device. Resident 7 reported that Resident 4 grabbed her by the wrists and squeezed them. She reported they were separated by one of the nurses and upon assessment, Resident 7's right lateral wrist was noted to have a dark, pea-sized bruise with no open skin. She also reported some discomfort to her wrist. Interview with Resident 7 on April 18, 2024, at 12:22 p.m. revealed that Resident 4 came in a few nights ago and grabbed her when she was in bed. Resident 7 stated she came in through the bathroom and told her to get out, that this was her house and her bed. Resident 7 stated that she still comes into her room, even though there is a stop sign on the bathroom door. She stated that Resident 4 also came in her room through the doorway to her room and went through her closet and drawers. Resident 7 stated that she does not feel safe ever since the incidents happened. There was no documented evidence that the facility evaluated Resident 7 to address the resident's fear and not feeling safe after the resident-to-resident incidents. Interview with the Director of Nursing on April 18, 2024, at 3:53 p.m. confirmed that there was no documented evidence that Resident 7 was assessed to address her fear and not feeling safe after the resident-to-resident incidents. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.