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	12/23/2024

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 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 polices 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 care needs for two of eight residents reviewed (Residents 2, 5). Findings include: A facility policy for Comprehensive Care Plans, dated November 18, 2024, indicated that a comprehensive, person-centered care plan is developed and implemented for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing and mental and psychosocial needs. The care planning coordinator will add minor changes in the resident's status to the existing care plans on a daily basis. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated December 5, 2024, indicated that the resident was cognitively impaired, required substantial assistance with bed mobility and transfers, had a history of two or more falls since the prior assessment, and had a diagnosis of dementia. A nursing note for Resident 2, dated December 4, 2024, at 9:20 a.m. revealed that Resident 2 had an unwitnessed fall and was found sitting on the floor beside her bed holding onto the enabler bar with her left hand. She was assisted into bed by two staff members without difficulty and had no injuries. An interdisciplinary post-fall review note, dated December 5, 2024, at 8:45 a.m. revealed that Resident 2 sustained an unwitnessed fall on December 4, 2024, where the resident was found on the floor alongside the bed in her room. There were no injuries reported. Interventions post fall included to discontinue the air mattress and issue a pressure-redistribution mattress. Therapy was to screen and evaluate/treat as indicated. Clinical record review for Resident 2 revealed that a bed and air mattress safety assessment was completed on December 4, 2024. A rehabilitation screen completed on December 6, 2024, indicated that the appropriate height of the mattress was marked with a decal for an identifier for staff to keep the bed at that level. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on December 23, 2024, at 2:45 p.m. revealed that Resident 2 had an air mattress on her bed, and there was a flower decal on the wall at the height of the mattress. There was no documented evidence that Resident 2's care plan was revised to reflect that the appropriate height of the mattress was marked with a decal for an identifier for staff to keep the bed at the appropriate level. Interview with the Director of Nursing on December 23, 2024, at 4:00 p.m. indicated that the initial intervention was to discontinue Resident 2's air mattress; however, after therapy evaluated the resident's air mattress, the plan was to place a decal on the wall to keep the mattress at that height. The Director of Nursing confirmed that Resident 2's care plan was not revised to reflect the intervention for the decal for identification to staff to keep the mattress at the appropriate level. A quarterly MDS assessment for Resident 5, dated October 18, 2024, indicated that the resident was cognitively impaired, required assistance with care needs, had a history of falls in last 30 days and two to six months prior to entry/reentry, and had a diagnosis of dementia. Observations on December 23, 2024, at 10:45 a.m. revealed that Resident 5 was in his room sleeping in a low bed. The low bed was in the lowest position, and there were bilateral fall mats on the floor on each side of his bed. There was no documented evidence that Resident 5's care plan was revised to reflect his need for a low bed and bilateral fall mats. Interview with the Assistant Director of Nursing on December 23, 2024, at 5:16 p.m. confirmed that Resident 5's care plan was not revised to reflect his need for the low bed and bilateral fall mats. 28 Pa. Code 201.24(e)(4) Admission Policy. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48941 Based on review of facility investigation documents and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that safe transfer techniques were used in accordance with their care plans for one of eight residents reviewed (Resident 1) resulting in a fall. Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated November 12, 2024, revealed that the resident was cognitively impaired, was understood and able to understand others, was dependent for transfers, had no history of falls, and had a diagnosis that included hemiparesis (weakness to one side of the body due to brain injury). A care plan for Resident 1, dated November 1, 2024, included an intervention with a start date of December 4, 2024, that indicated the resident's transfer status was moderate assistance (staff and the resident each put in half the effort) of two staff with use of the orbiturn (a transfer aid to facilitate standing and seat-to-seat transfers). A physical therapy discharge note, dated December 4, 2024, revealed that Resident 1 had improved with sit-to-stand transfer and pivot transfers to a moderate assist of two staff and use of the orbiturn with right upper extremity support and lateral support to the left lower extremity to improve tolerance to weight-bearing during transfers. A nursing note for Resident 1, dated December 11, 2024, at 4:05 p.m. revealed that the registered nurse was called to the third floor for a reported witnessed fall during a transfer. The resident was lying on the floor face down between the two beds. She had sneakers on bilateral feet and when asked what happened, the resident reported that she slid out of her chair when she sat down after the transfer . She reported some discomfort to her left arm. Bruising was noted to the left flank (lower back) and left posterior axilla (back side of armpit area) and she denied hitting her head. A witness statement completed by Nurse Aide 1, dated December 11, 2024, revealed that she was transferring Resident 1 into her chair with the orbiturn. She indicated that the resident was not on the chair fully and she slid off the chair and fell on to the floor. Nurse Aide 1 indicated that the wheelchair was locked and behind the resident prior to the fall. An interdisciplinary post fall review note, dated December 16, 2024, at 9:10 a.m., revealed that Resident 1 sustained a witnessed fall on December 11, 2024. When staff was attempting to transfer the resident, the resident began to slide off the chair and fell to the floor. The resident's transfer status was moderate assistance of two staff with use of the orbiturn. Interventions included staff education on proper transferring of Resident 1 and disciplinary action. A rehabilitation screening form, dated December 16, 2024, revealed that Resident 1's transfer status was downgraded to use the full body mechanical lift for transfers per the resident's request related to her fall on December 11, 2024, with staff and family. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A disciplinary action form for Nurse Aide 1, dated December 18, 2024, indicated that Nurse Aide 1 transferred Resident 1 without the assistance of facility staff. She transferred the resident with the orbiturn and the resident's private caregiver. Description of the counseling included that Nurse Aide 1 was educated on proper transfers and that residents who require a two-person assist for transfers are transferred with the facility staff, not a private caregiver. The education on transfers included: Transferring residents should only occur with Midtown Nursing/Therapy Employees and not with family, relatives, friends or personal or private caregivers from outside sources. Resident care plans and profiles must be checked each shift and throughout shift to be sure care plan interventions are followed for all care. Interview with the Director of Nursing on December 23, 2024, at 2:00 p.m. confirmed that Nurse Aide 1 did not follow Resident 1's care plan to transfer the resident using moderate assistance of two staff members and use of the orbiturn. She indicated that it was not known until further investigation that the nurse aide used the caregiver to assist with the transfer. The Director of Nursing indicated that she thought Nurse Aide 1 was technically following the care plan since she was still using two-person assistance with the transfer, despite that it was a caregiver and not staff. The education the facility provided indicated not to use outside sources to assist with transfers and to only use facility staff. The Director of Nursing indicated that the facility staff will be educated on transfers in the near future. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.