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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395985	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 48941 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to provide timely treatment to a newly identified pressure ulcer for one of 10 residents reviewed (Resident 9). Findings include: The facility's policy regarding skin and wound care best practices, dated November 18, 2024, indicated that pressure injuries and wounds will be treated with evidence-based interventions as ordered by the provider. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated November 19, 2024, revealed that the resident was cognitively intact, required substantial assistance with bed mobility, was incontinent of urine and frequently incontinent of bowel, was at risk for developing pressure ulcers (an injury to the skin and underlying tissue resulting from prolonged pressure), and had no unhealed pressure ulcers. A nursing note for Resident 9, dated December 28, 2024, at 3:25 p.m., revealed that the registered nurse was notified that the resident had a new pressure ulcer to her coccyx (tailbone). The area measured 0.5 x 1. 0 x 2.0 centimeters (cm) and was tunneling (a passage deeper under the skin that extends from the main wound bed into surrounding tissue) under upwards with no redness or drainage. The licensed practical nurse applied a foam dressing. The physician and the resident representative were notified, and an email was sent to the Assistant Director of Nursing to have the wound consultant see the resident the next time they were in the facility. There was no documented evidence in Resident 9's clinical record until December 31, 2024, that a physician's order was received to cleanse the resident's coccyx wound with Vashe (a wound cleanser that promotes healing), apply a 0.25 inch plain packing strip (for deep or tunneling wounds), pack loosely into the wound bed, and cover with an abdominal dressing (used for large or heavily draining wounds) daily and as needed. The order indicated that an Iodoform strip (a medicated packing with antiseptic/antimicrobial properties) may be substituted. The treatment was scheduled to start on January 1, 2025, on the day shift. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A wound note for Resident 9, dated January 3, 2025, revealed that she was seen by the consulting wound Certified Registered Nurse Practitioner (CRNP) related to the new ulceration to the resident's coccyx region that was identified on December 28, 2024. The wound was identified as a Stage 3 pressure ulcer (a full-thickness pressure wound involving the fat layers beneath the skin) that had worsened, measuring 1.5 x 1.3 x 1.0 cm and had a moderate amount of serosanguineous drainage (a wound drainage present with wound healing, infection, or trauma). Interview with the Director of Nursing on January 28, 2025, at 6:30 p.m. confirmed that the physician was notified of Resident 9's new pressure ulcer to her coccyx; however, a treatment was not ordered at that time and should have been. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48941 Based on review of clinical records, as well staff interviews, it was determined that the facility failed to ensure that residents received oxygen as ordered by the physician for one of 10 residents reviewed (Resident 10). Findings include: A nursing note for Resident 10, dated January 17, 2025, at 6:03 p.m. revealed that an admission assessment indicated that his lung sounds were clear and diminished. A diagnoses list for Resident 10 revealed that he was admitted with acute respiratory failure (blood does not have enough oxygen and causes difficulty breathing) with hypoxia (low levels of oxygen in body tissues). A nursing note for Resident 10, dated January 19, 2025, at 10:46 a.m. revealed that the registered nurse was called to resident's bedside by his daughter who came in to visit. She was reporting that the resident's oxygen was at a flow rate of 3 liters per minute (LPM) and his oxygen was to be at a flow rate of 4 LPM. Upon assessment, the resident's oxygen saturation (blood oxygen level) was 68 percent (normal oxygen saturation ranges are 95-100 percent) on an oxygen flow rate of 3 LPM via nasal cannula (a small tube that delivers oxygen through the nasal passages). His oxygen was increased to a flow rate of 5 LPM and his oxygen saturation increased to 77 percent. The nurse placed the resident on a non-rebreather mask (an oxygen mask that delivers high levels of oxygen) and his oxygen saturation increased to 93 percent, but the resident's mental status remained unchanged at that time. The physician was notified, and an order was obtained to send the resident to the hospital. The resident was admitted with pneumonia, hypoxia, and non-ST-elevation myocardial infarction (NSTEMI - type of heart attack that occurs when the heart's need for oxygen cannot be met). Physician's orders for Resident 10, dated January 18, 2025, included an order for the resident to receive continuous oxygen at a flow rate of 4 LPM via nasal cannula. Interview with the Director of Nursing on January 28, 2025, at 6:30 p.m. confirmed that Resident 10's oxygen flow rate should have been set at 4 LPM continuously as per physician order, and it was not as per the documentation. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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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. 48941 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from significant medication errors for one of 10 residents reviewed (Resident 1). Findings include: An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated January 9, 2025, revealed that the resident was cognitively intact, was independent to set up with care needs, used oxygen, and had diagnoses that included chronic obstructive pulmonary disease (COPD) (chronic lung disease making breathing difficult) and asthma (a lung disease making it difficult to breathe). Physician's orders for Resident 1, dated March 3, 2024, included orders for the resident to receive one puff/inhalation of fluticasone propionate inhaler 100 micrograms (mcg) twice daily for the morning medication pass between 7:00 a.m. and 11:00 a.m. and for the evening medication pass between 8:00 p.m. and 11:00 p.m. Review of Resident 1's Medication Administration Record (MAR) for January 2025 revealed that the fluticasone propionate inhaler was documented as not administered or on hold due to the medication being unavailable in the Omnicell (an automated dispensing machine for medications) or waiting for delivery from the pharmacy on the following dates/times: January 11 and 12 morning and evening; January 14, 15, and 16 evening; and January 17 and 18 morning. A nursing note for Resident 1, dated January 14, 2025, at 10:28 p.m., indicated that the registered nurse was notified that the resident did not have her fluticasone propionate inhaler and that it was not stocked in the Omnicell. A nursing note for Resident 1, dated January 15, 2025, at 10:10 a.m., indicated that the registered nurse spoke with the pharmacy regarding the fluticasone propionate inhaler and was told that it will be delivered that evening. Interview with Resident 1 on January 28, 2025, at 1:17 p.m. revealed that they run out of medication, and she cannot understand why they cannot order it before they run out. Interview with the Director of Nursing on January 28, 2025, at 3:33 p.m. confirmed that there was no documented evidence that Resident 1's fluticasone propionate inhaler was administered on the above-mentioned dates/times. She was unaware that the medication was not available, and she could not explain why there was documentation that the medication was administered between that dates that it was documented as not being available. She indicated that they usually had no issues with deliveries from the pharmacy and had no documentation to indicate why the medication would not have been delivered or ordered when they were running low. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.