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	08/06/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on review of the Pennsylvania Nurse Practice Act and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were clarified when needed for two of 12 residents reviewed (Residents 1, 2).Findings include:The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain and restore the well-being of individuals.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated May 23, 2025, revealed that the resident was understood, could understand others, had a diagnosis of included end-stage renal disease (ESRD - a permanent condition that occurs when the kidneys are no longer able to function properly), and received hemodialysis (a treatment that removes waste products and excess fluid from the blood when the kidneys are no longer functioning properly). A care plan for the resident, dated July 17, 2025, revealed that the resident received dialysis on Tuesday, Thursday, and Saturday. Physician's orders for Resident 1, dated May 19, 2025, included an order that the resident was to receive dialysis on Tuesday, Thursday, and Saturday at 6:15 a.m. Physician's orders for Resident 1, dated May 19, 2025, included an order that on dialysis days staff could administer the resident's medications prior to dialysis. Physician's orders for Resident 1, dated May 19, 2025, included an order that on dialysis days staff could administer the resident's medications upon return from dialysis. There was no documented evidence that Resident 1's physician was contacted to clarify which medications could be administered prior to dialysis and/or upon return from dialysis. A quarterly MDS assessment for Resident 2, dated June 2, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, had a diagnosis which included end-stage renal disease (ESRD - a permanent condition that occurs when the kidneys are no longer able to function properly), and was receiving dialysis.Physician's orders for Resident 2, dated July 24, 2025, included an order that the resident was to receive dialysis on Tuesday, Thursday, and Saturday at 11:00 a.m. Physician's orders for Resident 2, dated July 24, 2025, included an order that on dialysis days staff could administer the resident's medications prior to dialysis. Physician's orders for Resident 2, dated July 24, 2025, included an order that on dialysis days staff could administer the resident's medications upon return from dialysis. There was no documented evidence that Resident 2's physician was contacted to clarify which medications could be administered prior to dialysis and/or upon return from dialysis. Interview with the Director of Nursing on August 6, 2025, at 4:30 p.m. confirmed that there was no documented evidence that Resident 1 and Resident 2's physicians were contacted to clarify which medications could be administered prior to dialysis and/or upon return from dialysis. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents received care and treatment in accordance with professional standards of practice, by failing to ensure that physician's orders were followed for two of 12 residents reviewed (Residents 1, 2), and failed to follow recommendations from the orthopedist (a medical doctor specializing in the diagnosis, treatment, and prevention of musculoskeletal system disorders) for a therapy evaluation for one of 12 residents reviewed (Resident 2).Findings include: Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated May 23, 2025, revealed that the resident was understood, could understand others, had a diagnosis which included end-stage renal disease (ESRD - a permanent condition that occurs when the kidneys are no longer able to function properly), and received hemodialysis (a treatment that removes waste products and excess fluid from the blood when the kidneys are no longer functioning properly). A care plan for the resident, dated July 17, 2025, revealed that the resident received dialysis on Tuesday, Thursday, and Saturday. Physician's orders for Resident 1, dated May 19, 2025, included an order that the resident was to receive dialysis on Tuesday, Thursday, and Saturday at 6:15 a.m. Physician's orders for Resident 1, dated May 19, 2025, included an order that on dialysis days staff could administer the resident's medications prior to dialysis. Physician's orders for Resident 1, dated May 19, 2025, included an order that on dialysis days staff could administer the resident's medications upon return from dialysis. Physician's orders for Resident 1, dated May 19, 2025, and discontinued on June 24, 2025, included an order for the resident to receive one 10 milligram (mg) tablet of Amlodipine (used to treat high blood pressure) once a day. Physician's orders for Resident 1, dated May 19, 2025, included an order for staff to administer one 0.8-15 mg tablet of Dialyvite 800 with Zinc 15 (replenish nutrients, ensuring that patients receive adequate levels of crucial vitamins) once a day. Physician's orders for Resident 1, dated May 19, 2025, included an order for staff to administer one 10 mg tablet of Escitalopram (use to treat depression) once a day. Physician's orders for Resident 1, dated May 19, 2025, included an order for staff to administer one 75 mg tablet of Plavix (a medication to prevent blood clots) once a day. Physician's orders for Resident 1, dated May 29, 2025, included an order for staff to administer two tablets of Vitamin D3 (a dietary supplement) once a day. Physician's orders for Resident 1, dated June 6, 2025, included an order for staff to administer two 210 mg tablets of Auryxia (to treat high phosphorus levels in adults with chronic kidney disease (CKD) on dialysis) with meals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's orders for Resident 1, dated June 24, 2025, included an order for staff to administer one 25 mg tablet of Metoprolol (used alone or in combination with other medications to treat high blood pressure) once a day. Review of Resident 1's Medication Administration Records for June, July, and August 2025, revealed: There was no documented evidence that staff administered the one 10 mg tablet of Amlodipine to Resident 1 prior to dialysis or upon return from dialysis on Tuesday June 3, 17, and 24, 2025, and on Thursday June 12, 2025. There was no documented evidence that staff administered the one 0.8-15 mg tablet of Dialyvite 800 with Zinc 15 to Resident 1 prior to dialysis or upon return from dialysis on Tuesday June 3, 17, and 24, 2025, and July 15, 2025, on Thursday June 12, and 26, 2025, and July 3 and 31, 2025, and on Saturday July 5 and 19, 2025. There was no documented evidence that staff administered the one 10 mg tablet of Escitalopram to Resident 1 prior to dialysis or upon return from dialysis on Tuesday June 3, 17, and 24, 2025, and July 15, 2025, on Thursday June 12, and 26, 2025, and July 31, 2025, and on Saturday July 5 and 19, 2025. There was no documented evidence that staff administered the one 75 mg tablet of Plavix to Resident 1 prior to dialysis or upon return from dialysis on Tuesday June 3, 17, and 24, 2025, and July 15, 2025, on Thursday June 12, and 26, 2025, and July 31, 2025, and on Saturday July 5 and 19, 2025. There was no documented evidence that staff administered the two tablets of Vitamin D3 to Resident 1 prior to dialysis or upon return from dialysis on Tuesday June 3, 17, and 24, 2025, and July 15, 2025, on Thursday June 12, and 26, 2025, and July 10 and 31, 2025, and on Saturday June 7, 2025, and July 5 and 19, 2025. There was no documented evidence that staff administered the two 210 mg tablets of Auryxia to Resident 1 prior to dialysis or upon return from dialysis at 8:00 a.m. on Tuesday June 17 and 24, 2025, and July 1, 8, 15, and 22, 2025, on Thursday June 12, and 26, 2025, and July 3, 10, and 31, 2025, and on Saturday June 7 and 28, 2025, and July 5, 12,and 19, 2025, and at 12:00 p.m. on Tuesday June 24, 2025, and July 15, 2025, and on Saturday July 5, 2025. There was no documented evidence that staff administered the one 25 mg tablet of Metoprolol to Resident 1 prior to dialysis or upon return from dialysis on Tuesday July 15, 2025, on Thursday June 26, 2025, and July 31, 2025, and on Saturday July 5, and 19, 2025, and August 2, 2025. An quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated June 2, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, had diagnosis which included end-stage renal disease (ESRD - a permanent condition that occurs when the kidneys are no longer able to function properly) and Parkinson's disease (a progressive brain disorder that affects movement), and was receiving dialysis. The care plan for resident 2 dated March 20, 2025, indicated that the resident was receiving dialysis at a dialysis center every Tuesday, Thursday, and Saturday and staff were to assure medications were administered before and after dialysis as ordered by the physician to ensure maximum effectiveness and to avoid adverse effects of the medications. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's orders for Resident 2, dated July 24, 2025, included an order that the resident was to receive dialysis on Tuesday, Thursday, and Saturday at 11:00 a.m. Physician's orders for Resident 2, dated July 24, 2025, included an order that on dialysis days staff could administer the resident's medications prior to dialysis. Physician's orders for Resident 2, dated July 24, 2025, included an order that on dialysis days staff could administer the resident's medications upon return from dialysis. Physician's orders for Resident 2, dated June 3, 2025, included for staff to administer two five milligrams (mg) midodrine (medication primarily used to treat low blood pressure) tablets three times a day. Physician's orders for Resident 2, dated May 28, 2025, included for staff to administer one-half of a 500 mg tablet of methocarbamol (muscle relaxant primarily used for short-term relief of muscle pain and spasms) three times a day. Physician's orders for Resident 2, dated May 28, 2025, included for staff to administer one 25-100 mg carbidopa-levodopa (used to treat the symptoms of Parkinson's disease) tablet three times a day. Review of Resident 2's Medication Administration Records for July, and August 2025, revealed: There was no documented evidence that staff administered 3:00 p.m. dose of two five mg midodrine tablets to Resident 2 prior to dialysis or upon return from dialysis on Tuesday July 8 and 22, 2025, on Thursday July 10, 17, and 31, 2025, and on Saturday July 12, 2025. There was no documented evidence that staff administered 2:00 p.m. dose of one-half of a 500 mg methocarbamol tablet to Resident 2 prior to dialysis or upon return from dialysis on Tuesday July 8, 15, and 22, 2025, on Thursday July 10, 17, 24, and 31, 2025, and on Saturday July 12, 2025. There was no documented evidence that staff administered 2:00 p.m. dose of one 25-100 mg carbidopa-levodopa tablet to Resident 2 prior to dialysis or upon return from dialysis on Tuesday July 8, 15, 22, and 26, 2025, on Thursday July 10, 17, 24, and 31, 2025, and on Saturday July 12, 2025. Interview with the Director of Nursing on August 6, 2025, at 4:30 p.m. confirmed that there was no documented evidence that on the above dates and times, the above medications were administered by staff to Residents 1 or 2 prior to dialysis and/or upon return from dialysis. The Director of Nursing revealed medications that are given three times a day may be too close to the next dose if given before or after dialysis, however, it was not clarified with the physician. Therapy documentation for Resident 2, dated June 13, 2025, indicated that a therapy referral was requested by the orthopedic physician at the consult appointment. Physician’s orders for Resident 2, dated June 13, 2025, included an order for a therapy screening per the orthopedic consult. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Rehabilitation on August 6, 2025, at 2:15 p.m. revealed that Resident 2 received therapy services from May 29, 2025, through June 12, 2025 and that a therapy screen had not been conducted as ordered on June 13, 2025. Interview with the Director of Nursing on August 6, 2025, at 4:25 p.m. confirmed that Resident 2 was ordered to have a therapy screen on June 13, 2025; however, the screening was not completed and should have been. 28 Pa. Code 211.12(d)(1)(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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on review of clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that residents who required urinary catheterization (a flexible tube inserted into the bladder to drain urine) was completed as ordered for one of 12 residents reviewed (Resident 2).Findings include:An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2 revealed that the resident was cognitively intact, required assistance for care needs, had a diagnosis of end stage kidney failure and received dialysis three times per week. A care plan for Resident 2, dated March 3, 2025, indicated that the resident had urinary incontinence, and was to be provided straight catheterization (a medical procedure used to drain urine from the bladder using a thin, flexible tube called a straight catheter) as ordered.Physician's orders for Resident 2, dated May 28, 2025, included an order for the resident to be straight catheterized three times a day (once every shift) for a neurogenic bladder. Physician's orders for Resident 2, dated July 24, 2025, included an order that the resident was to receive dialysis on Tuesday, Thursday, and Saturday at 11:00 a.m. Review of Resident 2's July and August, 2025 medication and treatment administration records (MAR and TAR) revealed that the resident did not receive straight catheterization on July 1, 3, 8 10, 17, 24, 2025, on day shift because the resident was at dialysis. Resident 2 did not leave for dialysis until 10:30 a.m. Documentation for July 5 and 19, 2025 for day shift as well as July 23 and 31, 2025 for evening shift indicated the resident was not available. On August 4, 2025, Resident 2 was not straight catheterized because it was completed on the previous shift. On August 5, 2025, day shift Resident 2 was not catheterized due to being at dialysis, and it was not completed on night shift.Interview with the Director of Nursing on August 6 2025, at 4:25 p.m. confirmed that there was no documented evidence that Resident 2's straight catheterization was completed as ordered on the dates and shifts noted above.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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on review of policies and clinical records, as well as observations and resident and staff interviews, it was determined that the facility failed to follow facility policy for the care and monitoring of residents receiving dialysis for one of 12 residents reviewed (Resident 2). Findings include: A facility policy for Hemodialysis Care, dated April 29, 2025, indicated that communication between the dialysis provider and the facility will occur before and after each hemodialysis treatment and as needed. Pre-dialysis, the staff are to document an assessment in the dialysis communication tool, print the tool and send it with the resident to dialysis. Post dialysis, staff are to receive report from the dialysis provider and/or review the dialysis communication tool documentation by the dialysis provider and contact dialysis promptly with any questions or concerns. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated June 2, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, had a diagnosis which included end-stage renal disease (ESRD - a permanent condition that occurs when the kidneys are no longer able to function properly), and was receiving dialysis. Physician's orders for Resident 2, dated July 24, 2025, included an order that the resident was to receive dialysis on Tuesday, Thursday, and Saturday at 11:00 a.m. The care plan for Resident 2, dated March 20, 2025, indicated that the resident was receiving dialysis at a dialysis center every Tuesday, Thursday, and Saturday. Review of Resident 2's clinical record, an observations of the nursing station, revealed no evidence that any form of resident assessments or communication related to the resident's health status before and after dialysis was being shared between the facility and the dialysis center. Interview with the Director of Nursing on August 6, 2025, at 5:23 p.m. confirmed that there was no documented evidence that pre-dialysis assessments were sent with the resident to the dialysis center and there was no evidence that post dialysis information was received from the dialysis center and reviewed by staff per the facility policy. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on a review of facility policies, observations, and staff interviews, it was determined that the facility failed to serve food items that were palatable.Findings include: The facility's policy regarding food temperatures, dated April 29, 2025, revealed that hot food should be palatable at point of delivery. Observations of the lunch meal tray line on August 6, 2025, at 11:41 a.m. revealed that dietary staff began to prepare the second floor low hall cart. At 12:04 p.m. the second floor low hall cart arrived on the unit and at 12:14 p.m. all but one of the trays from that cart were delivered to the residents. A test tray completed on August 6, 2025, at 12:16 p.m. revealed that the milk was 45.4 degrees Fahrenheit and tasted cold, the orange juice was 51.4 degrees Fahrenheit, the coffee was 142 degrees Fahrenheit, the beef stew was 117 degrees Fahrenheit and tasted cold and was not palatable, and the cauliflower was 129 degrees Fahrenheit, unseasoned, tasted cold and overcooked, and was not palatable. Interview with the Dietary Manager on August 6, 2025, at 12:18 p.m. confirmed that beef stew was cold and not palatable, and that the cauliflower was mushy, and had no seasoning. 28 Pa. Code 201.18(b)(1)(2)(e) Management. 28 Pa. Code 211.6(c) Dietary Services.