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Form Approved OMB
No. 0938-0391

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	02/12/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that resident-centered care plans were implemented for one of six residents reviewed (Resident 2) regarding nutritional interventions. Findings include: A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated September 4, 2025, revealed that the resident was cognitively impaired and dependent on staff for daily care tasks, including feeding. The resident's care plan, most recently updated September 4, 2025, indicated that the resident had increased nutrition risk related to needing to be fed by staff and having swallowing difficulties. The resident's care plan indicated that the resident was to be offered an alternative meal if she consumed less than fifty percent of the meal.According to Resident 2's meal intake record, dated November 2025, the resident ate less than fifty percent for supper on November 1, for lunch on November 2, for breakfast and lunch on November 3, for breakfast and lunch on November 6, for breakfast and lunch on November 8, for dinner on November 10, for lunch on November 11, for lunch on November 14, for breakfast and lunch on November 15, for breakfast and dinner on November 16, for breakfast and lunch on November 17, for breakfast and lunch on November 18, for breakfast on November 20, and for breakfast and lunch on November 21.There was no documented evidence that the resident was offered an alternative meal on the dates mentioned above. Interview with the Director of Nursing on February 12, 2026 at 2:14 p.m. revealed that there was no indication that Resident 2 was offered an alternative meal on those dates and that she should have been according to her care planned intervention.28 Pa. Code 201.24(e)(4) admission Policy.

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on clinical record reviews and staff interviews, it was determined that the facility failed to initiate nutritional interventions to assure that residents were offered sufficient food and fluid intake to maintain proper hydration and health for one of six residents reviewed (Resident 2). Findings include:A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated September 4, 2025, revealed that the resident was cognitively impaired and dependent on staff for daily care tasks, including feeding. The resident's care plan, most recently updated September 4, 2025, indicated that the resident had increased nutrition risk related to needing to be fed by staff and having swallowing difficulties. The resident's care plan indicated that the resident was to be offered an alternative meal if she consumed less than fifty percent of the meal. The resident was to be spoon fed nectar thick liquids by staff.According to Resident 2's meal intake record, dated November 2025, the resident ate less than fifty percent for supper on November 1, for lunch on November 2, for breakfast and lunch on November 3, for breakfast and lunch on November 6, for breakfast and lunch on November 8, for dinner on November 10, for lunch on November 11, for lunch on November 14, for breakfast and lunch on November 15, for breakfast and dinner on November 16, for breakfast and lunch on November 17, for breakfast and lunch on November 18, for breakfast on November 20, and for breakfast and lunch on November 21.A nursing note for Resident 2, dated November 23, 2025 at 2:09 p.m., revealed that the resident's sister was concerned regarding her recent poor intake and lethargy. A nursing note for Resident 2, dated November 23, 2025 at 3:24 p.m. revealed that the resident was found unresponsive, in respiratory distress, and was transferred to the hospital for further evaluation.A nursing note for Resident 2, dated November 23, 2025 at 8:48 p.m. revealed that the resident was admitted to the hospital with hyponatremia (low sodium), urinary tract infection and pneumonia. There was no documented evidence that the resident was offered an alternative meal or fluids for hydration on the dates mentioned above. Interview with the Director of Nursing on February 12, 2026 at 2:14 p.m. revealed that there was no indication that Resident 2 was offered an alternative meal or fluids on those dates and that she should have been 28 Pa. Code 211.12(d)(3) Nursing services.28 Pa. Code 211.12(d)(5) Nursing services.